

# Patient Health History

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Today's Date

Signature of Patient \_\_\_\_\_

Patient Title: *(check one)*     Mr.    Mrs.    Ms.    Miss    Dr.    Prof.    Rev.

First Name \_\_\_\_\_ Nick Name \_\_\_\_\_

Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Suffix \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Is it ok to call you at work?    yes    no

Home email \_\_\_\_\_ Work Email \_\_\_\_\_

Which email address would you like us to use to communicate with you? *(check one)*     Home     Work

Contact Method *(check one)*

Primary Phone     Secondary Phone     Mobile Phone     Home Email     Work Email

Date of Birth

Age \_\_\_\_\_ Gender *(check one)*     Male     Female     Unspecified

Marital Status *(check one)*     Single     Married     Other    SSN \_\_\_\_\_

Employment Status *(check one)*     Employed- Employer : \_\_\_\_\_

FT Student     PT Student     Other     Retired     Self Employed

Race *(check one)*

- |                                   |   |                                      |  |
|-----------------------------------|---|--------------------------------------|--|
| <input type="checkbox"/> White    | <input type="checkbox"/> Black/African American | <input type="checkbox"/> Hispanic    | <input type="checkbox"/> American Indian/Alaskan Native          |
| <input type="checkbox"/> Asian    | <input type="checkbox"/> Asian Indian           | <input type="checkbox"/> Chinese     | <input type="checkbox"/> Filipino                                |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean                 | <input type="checkbox"/> Vietnamese  | <input type="checkbox"/> Native Hawaiian or other Pacific Island |
| <input type="checkbox"/> Samoan   | <input type="checkbox"/> Guamanian or Chamorro  | <input type="checkbox"/> Other _____ | <input type="checkbox"/> I choose not to specify                 |

Multi-Racial *(check one)*     Yes     No     Unknown

Ethnicity *(check one)*     Hispanic or Latino     Not Hispanic or Latino     I choose not to specify

Preferred Language *(check one)*

- |                                  |                                     |   |  |  |                                 |
|----------------------------------|-------------------------------------|---|--|--|---------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish    | <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Chinese       | <input type="checkbox"/> French                  | <input type="checkbox"/> German |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Italian                | <input type="checkbox"/> Korean        | <input type="checkbox"/> Russian                 | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Arabic  | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Japanese               | <input type="checkbox"/> French Creole | <input type="checkbox"/> Greek                   | <input type="checkbox"/> Hindi  |
| <input type="checkbox"/> Persian | <input type="checkbox"/> Urdu       | <input type="checkbox"/> Gujarati               | <input type="checkbox"/> Armenian      | <input type="checkbox"/> I choose not to specify |                                 |



Patient Name: \_\_\_\_\_

**How did you hear about our clinic? Or who referred you? Name:** \_\_\_\_\_

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Family Member | <input type="checkbox"/> Employer         | <input type="checkbox"/> Internet web site | <input type="checkbox"/> Google ad      |
| <input type="checkbox"/> Friend        | <input type="checkbox"/> Yellow pages     | <input type="checkbox"/> Billboard         | <input type="checkbox"/> Brochure       |
| <input type="checkbox"/> Physician     | <input type="checkbox"/> Newspaper ad     | <input type="checkbox"/> Health class      | <input type="checkbox"/> Direct mail ad |
| <input type="checkbox"/> Attorney      | <input type="checkbox"/> Sign on building | <input type="checkbox"/> Radio             | <input type="checkbox"/> Other          |

**Insurance Information**

Type of Insurance: None/Self Pay Auto Health Medicare Work Injury Other

Insurance Company Name: \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Insured-Policy Holder Information**  *this information is not applicable, patient is the policy holder*

Insured/Policy Holder's Name: _____ Insured's DOB _____ <i>If someone other than the patient</i>
Relationship to Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other _____
Insured's Sex: <input type="checkbox"/> M <input type="checkbox"/> F Insured's Employer: _____
Home Address _____ Street/City,State/Zip
Home Telephone: _____ Work Telephone: _____

If your primary insurance is Medicare, please make sure we get a copy of your Medicare supplement insurance card. Thanks

**Auto only:** Claim number \_\_\_\_\_ Adjuster's Name \_\_\_\_\_

**Accident Injury Information**

Are your present problems due to an accident-injury? Yes No Date of Accident \_\_\_\_\_

Type of accident-injury: Auto Work Injury Sports Military Household Slip/Fall Other

Name of Attorney \_\_\_\_\_ Phone \_\_\_\_\_

**Primary Care Physician**

**Referring Physician** not applicable

Name: _____
Street Address: _____
Suite No. <i>if applicable</i> ) _____
City: _____ State: _____ Zip _____
Telephone: _____

Name: _____
Street Address: _____
Suite No. <i>if applicable</i> ) _____
City: _____ State: _____ Zip _____
Telephone: _____

Patient Name \_\_\_\_\_

## **OFFICE POLICIES**

**Appointments:** Your appointment time is reserved for you. Please take note of the following policies as it pertains to appointments with Taber Chiropractic, PC:

1. If you find it necessary to reschedule an appointment, please call prior to appointment, that we might make that time available to someone else that is in need.
2. For appointments cancelled or missed with less than the minimum notice, ***it will be necessary to charge \$25 FOR EACH SERVICE APPOINTMENT***
3. We give exceptions to missed appointments due to extreme illness and/or inclement weather
4. There is a **ONE** visit grace for not calling prior to your appointments
5. Please call if you are running late for your scheduled appointments

**Payment:** Please take note of the following financial policies with Taber Chiropractic, PC:

1. We accept Cash, local checks, and Visa/MasterCard/American Express.
2. Payment is due at time of service unless other arrangements have been made in advance. In the event that you fail to make payment when due, this account (and any accounts you are responsible for) will be referred to a collection agency for collection. In that event, the contingency fee assessed by the collection agency will be added to the principle and interest due. You'll be additionally liable for the collection agency fees and attorney fees will increase the balance you owe.
3. To save time we recommend EXPRESS CHECK-OUT. If you pre-pay and pre-schedule your appointments you can save time each visit and bypass the front desk on your way out.
4. There is a \$25.00 returned check fee, should your payment by check be returned by your financial institution/bank.

## **INSURANCE AUTHORIZATION OF TREATMENT**

1. I am ultimately responsible for full payment for any and all services rendered.
2. I am considered a CASH patient until I have provided completed insurance forms, and that your office has qualified and accepted my coverage, otherwise I pay at the time of service.
3. I must pay deductibles, co pays and coinsurance at the time of service.
4. Insurance Benefits quoted by my insurance company are NOT a guarantee of benefits or payment.
5. Taber Chiropractic, PC make every attempt to receive authorization of treatment from insurance companies for treatment received at one of our facilities. However, there may be times when the insurance company does not provide this authorization in a timely or correct manner. Taber Chiropractic, PC will submit claims as a courtesy to me. If my insurance carrier has not paid a claim within the terms of the contract within 60 days of submission, Taber Chiropractic, PC will submit an appeal one (1) time. If the claim is not paid within 30 days of the appeal I will be responsible for taking an active part in the recovery of my claim. After 90 days, I will be responsible for the balance and I authorize the use my credit card, (if supplied) to collect full payment, otherwise I must remit payment in full upon receipt of the bill.
6. In the event I discontinue my plan of care prior to the doctor's consent, I am responsible for any outstanding balance and the courtesy of insurance assignment is immediately discontinued.
7. If my account is turned over to collections, I agree to pay all fees.

## **TREATMENT CONSENT AND WAIVER**

I hereby request and consent to the performance of chiropractic and/or physical therapy procedures, including various modes of physical therapy, on me (or for the patient I am legally responsible for) by the doctor(s) at Taber Chiropractic, PC. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic/physical therapy there are some risks to treatment, including but not limited to, fractures, disc injuries, stroke, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, in my best interest.

## **NOTICE OF PRIVACY PRACTICES AND PATIENT'S RIGHTS AND RESPONSIBILITIES**

### **Please Check:**

I acknowledge that I was offered a copy of the Notice of Privacy Practices & Patient's Rights and Responsibilities by Taber Chiropractic, PC

## **ASSIGNMENT OF BENEFITS**

I, the undersigned, have insurance coverage with \_\_\_\_\_ and assign directly to Taber Chiropractic, PC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. I understand that if I terminate my care and treatment, any fees or professional services rendered to me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Cardiovascular:**

	No _____		
	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Vascular Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

**Genitourinary:**

	No _____		
	Present	Past	No
Kidney Disease			
Burning Urination			
Frequent Urination			
Blood in Urine			
Kidney Stone			

**Hematologic/lymphatic:**

	No _____		
	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

**Psychiatric:**

	No _____		
	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

**Constitutional:**

	No _____		
	Present	Past	No
Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

**Surgeries**

Appendectomy	<input type="checkbox"/>
Joint Replacement	<input type="checkbox"/>
Cardiovascular Procedure	<input type="checkbox"/>
Laminectomy	<input type="checkbox"/>
Cervical Disc Procedure	<input type="checkbox"/>
Low Back Procedure	<input type="checkbox"/>

**Respiratory:**

	No _____		
	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Chronic Cough			
Sleep Apnea			

**Ears/Nose/Throat:**

	No _____		
	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Problems			
Nosebleed			
Difficulty Swallowing			

**Eyes:**

	No _____		
	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

**Integumentary:**

	No _____		
	Present	Past	No
Skin Lesions			
Skin Ulcers			
Eczema			
Psoriasis			
Rashes			

**Neurologic:**

	No _____		
	Present	Past	No
Babinski			
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Carpal Tunnel			
Spinning/Balance			

**Allergic/Immunologic:**

	No _____		
	Present	Past	No
Immune Disorder			
HIV/AIDS			
Cortisone Use			

**Gastrointestinal:**

	No _____		
	Present	Past	No
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

**Musculoskeletal:**

	No _____		
	Present	Past	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

**Endocrine:**

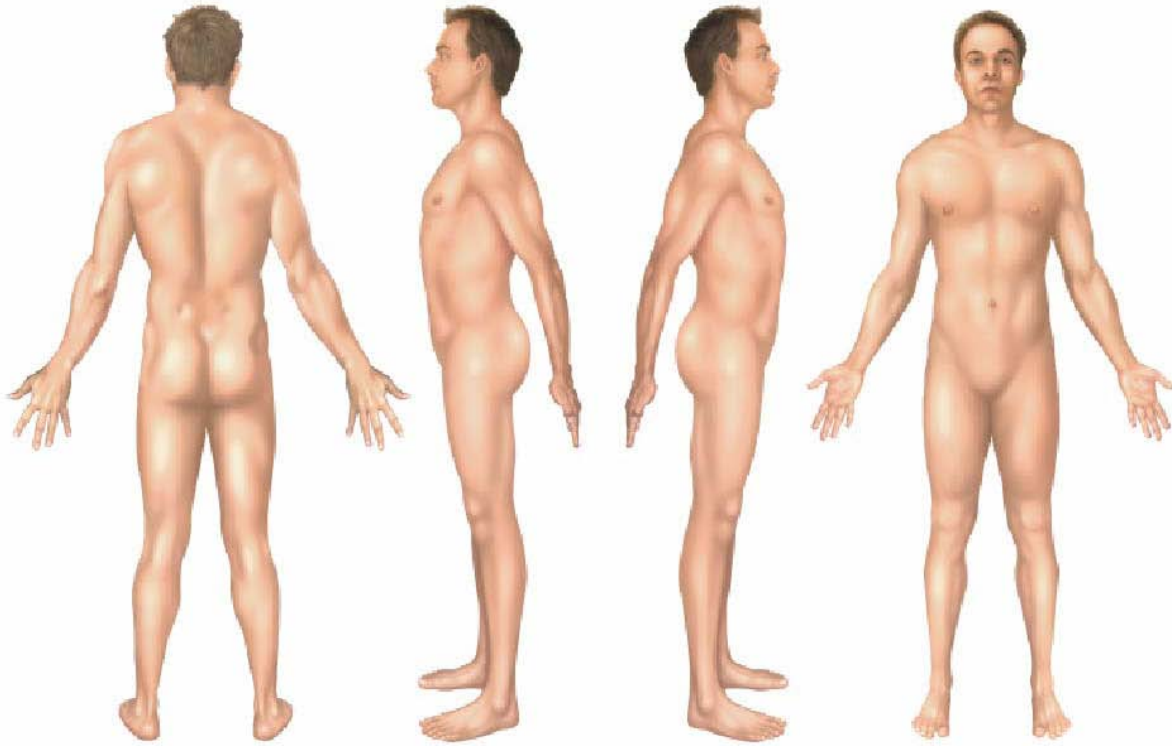
	No _____		
	Present	Past	No
Thyroid Disease			
Diabetes			
Menopausal			
Menstrual Problems			
Menstrual Cramping			

**Family History (circle Parent or Sibling )**

Arthritis (Parent/Sibling)	
Cholesterol (Parent/Sibling)	
Heart Problems (Parent/Sibling)	
Cancer (Parent/Sibling)	
Diabetes (Parent/Sibling)	
High Blood Pressure (Parent/Sibling)	
Stroke (Parent/Sibling)	

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

# = Numbness    X = Burning    / = Stabbing    0 = Pins & Needles    + = Dull Ache



Have you seen a chiropractor in the past?     No     Yes    When: \_\_\_\_\_

For what condition? \_\_\_\_\_

For the following questions (1-13), answer the questions for your main (chief) complaint.  
 (For example: neck pain or back pain). Area: \_\_\_\_\_

1. During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Trip to ER)

- |                                 |                                       |  |                            |
|---------------------------------|---------------------------------------|--|----------------------------|
| <input type="checkbox"/> 0 None | <input type="checkbox"/> 1            | <input type="checkbox"/> 2             | <input type="checkbox"/> 3 |
| <input type="checkbox"/> 4      | <input type="checkbox"/> 5            | <input type="checkbox"/> 6             | <input type="checkbox"/> 7 |
| <input type="checkbox"/> 8      | <input type="checkbox"/> 9 Unbearable | <input type="checkbox"/> 10 Trip to ER |                            |

2. How did your symptoms begin? \_\_\_\_\_

3. When did your symptoms start? Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

4. How often do you experience your symptoms?

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Constantly<br>(76-100% of the day) | <input type="checkbox"/> Frequently<br>(51-75% of the day) | <input type="checkbox"/> Occasionally<br>(26-50% of the day) | <input type="checkbox"/> Intermittently<br>(0-25% of the day) |
|---|--|--|---|

4A. Are your symptoms worse:     in the morning     by midday     at the end of the day     at night     throughout day

5. What describes the nature of your symptoms?

- |   |                                   |  |                                    |
|---|-----------------------------------|--|------------------------------------|
| <input type="checkbox"/> dull                   | <input type="checkbox"/> sharp    | <input type="checkbox"/> sharp with movement | <input type="checkbox"/> throbbing |
| <input type="checkbox"/> burning                | <input type="checkbox"/> deep     | <input type="checkbox"/> aching              | <input type="checkbox"/> tingling  |
| <input type="checkbox"/> stabbing               | <input type="checkbox"/> cramping | <input type="checkbox"/> pinprick            | <input type="checkbox"/> numbness  |
| <input type="checkbox"/> radiating type of pain |                                   |  |                                    |

6. Are your symptoms radiating?  Yes  No

Describe: \_\_\_\_\_  
\_\_\_\_\_

7. What activities aggravate your pain?

- |                                     |   |  |
|-------------------------------------|---|--|
| <input type="checkbox"/> sitting    | <input type="checkbox"/> standing       | <input type="checkbox"/> walking               |
| <input type="checkbox"/> bending    | <input type="checkbox"/> stooping       | <input type="checkbox"/> lifting               |
| <input type="checkbox"/> sleeping   | <input type="checkbox"/> sneezing       | <input type="checkbox"/> coughing              |
| <input type="checkbox"/> straining  | <input type="checkbox"/> twisting       | <input type="checkbox"/> reaching              |
| <input type="checkbox"/> looking up | <input type="checkbox"/> looking down   | <input type="checkbox"/> movement              |
| <input type="checkbox"/> rest       | <input type="checkbox"/> laying on back | <input type="checkbox"/> driving               |
| <input type="checkbox"/> typing     | <input type="checkbox"/> scooping       | <input type="checkbox"/> household chores      |
| <input type="checkbox"/> exercise   | <input type="checkbox"/> stair stepping | <input type="checkbox"/> Nothing aggravates it |

Other: \_\_\_\_\_

8. What activities relieve your pain?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> sitting                     | <input type="checkbox"/> standing                 | <input type="checkbox"/> laying down                                  |
| <input type="checkbox"/> knees are bent up           | <input type="checkbox"/> rest occurs              | <input type="checkbox"/> leaning against a support                    |
| <input type="checkbox"/> movement occurs             | <input type="checkbox"/> no movement occurs       | <input type="checkbox"/> analgesic topical pain relief gel is applied |
| <input type="checkbox"/> ice is applied              | <input type="checkbox"/> heat is applied          | <input type="checkbox"/> Nothing relieves it                          |
| <input type="checkbox"/> ibuprofen is taken          | <input type="checkbox"/> medication is used       |   |
| <input type="checkbox"/> stretching/exercise is used | <input type="checkbox"/> adjustments are provided |   |

Other: \_\_\_\_\_

9. Have you had any weakness, related to your complaint, in your arms/hands/legs/feet?

Describe \_\_\_\_\_  Yes  No

10. Have you had any bowel/bladder changes, since this complaint began?  Yes  No

11. Have you seen anyone in the past for this complaint?  Yes  No

Who? \_\_\_\_\_

12. Have you had any tests (radiology) done for this complaint?  Yes  No

What? \_\_\_\_\_

13. Have you had any major trauma in your past?  Yes  No

10. What do you hope to gain from your chiropractic care? \_\_\_\_\_

11. Do you have a goal of losing weight or would you like diet information?  Yes  No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_