WELCOME TO OUR OFFICE

Name _____ **Today's Date** _____

Address _____ **City** _____ **Zip** _____

Phone numbers Home _____ **Cell** _____ **Work** _____

SSN _____ **Birthdate** ___/___/___ **Marital Status M S W D**

Emergency Contact _____ **Phone Number** _____

Do we have your permission to contact you via text or email? Yes No

Employer _____

E-mail Address _____ **Hobbies** _____

Insured's Name (if different from patient) _____ **DOB** _____

How did you hear about our office: Internet Health Talk Physician Attorney Friend

Who referred you to the office? _____ **Work or auto injury ? Y N Date of injury** _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand West Jefferson Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company. I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to West Jefferson Chiropractic as payment for professional services rendered. However, I clearly understand and agree that I am personally responsible for payment.

Signed _____ Date _____

CONSENT FOR TREATMENT

I understand by signing below I am giving the doctors at West Jefferson Chiropractic consent to examine and provide treatment that the doctor believes is in my best interest. I am aware that any risks regarding care will be explained.

Signed _____ Date _____

PRIVACY NOTICE.

I am aware that West Jefferson Chiropractic is protecting my **PRIVATE** medical records in compliance with **HIPAA** guidelines. I understand that my information will be used for intra-office procedures and may be shared with other healthcare providers (with my permission) for the benefit of my healthcare. My records cannot be released without my written permission. The one-time written request is good for any subsequent request for records. I may revoke the permission for release of records in writing. I also understand that I may file a formal complaint with the privacy officer about any possible violations or these policies and procedures. I will let the office know if there is anyone that I DO NOT want to see my records. By signing below I acknowledge that I have received a written copy of the office's privacy policies

Signed _____ Date _____

Family Physician _____

Current Medications _____

_____

Other Physicians _____

Previous Surgeries _____

Allergies _____

Vitamins / Supplements / Herbs _____

_____

Please check any health complaints you are currently experiencing.

___ Headache
___ Migraine
___ Ringing in Ears
___ Dizziness
___ Neck Pain
___ Mid Back Pain
___ Low Back Pain
___ Hip Pain R L
___ Knee Pain R L

___ Foot Problems
___ Difficulty Sleeping
___ Fingers Go to Sleep
___ Arm / Hand Pain / Numbness
___ Leg Pain / Numbness
___ Carpal Tunnel Syndrome
___ Asthma / Allergies
___ Weight Gain / Loss
___ Sinus Problems

___ Ear Infections
___ Frequent Colds / Infections
___ Digestive Problems
___ High / Low Blood Pressure
___ Stress
___ Nervousness
___ Depression / Anxiety
___ Tension
___ Fatigue

Other _____

How would you rate your overall health? Excellent Good Fair Poor

Are you interested in improving your overall health? Yes No

PAST MEDICAL HISTORY

Have you ever had any of the following

Cancer	Y N	Liver Disease	Y N	Thyroid Disease	Y N
Kidney Disease	Y N	Diabetes	Y N	Heart Disease	Y N
Stroke	Y N	Hi Blood Pressure	Y N	Epilepsy	Y N

Other _____

Any Family Members have any of the above? Please list _____

_____

SOCIAL HISTORY

Tobacco	Y N	ppd___yrs___
Alcohol	Y N	drinks/ wk
Caffeine	Y N	cups/day
Illegal drugs	Y N	

Type:_____

FOR WOMEN ONLY

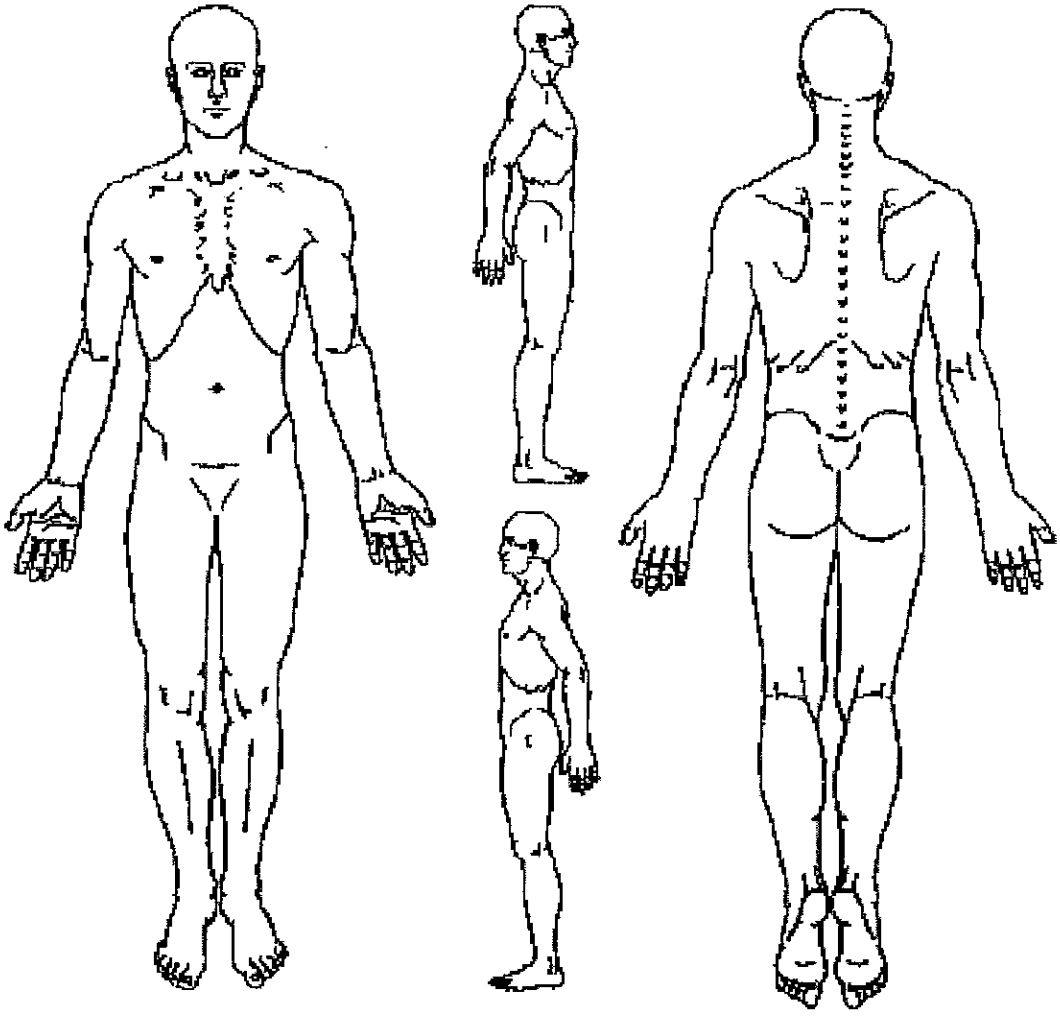
Are you Pregnant	Y N
Menstrual pain	Y N
Irregularity	Y N
Birth control _____	(type)
Hysterectomy	Y N
Ovaries present	Y N
Hot Flashes	Y N

PAIN CHART

Name_____ DOB____-____-____ Date____-____-____

Please mark on the body diagrams all areas of pain, discomfort, or altered sensation, and use the key below to identify quality of each.

A = ache	**B = burning**	**E = electrical**	**S = stabbing**
P = pins & needles	**N = numb**	**O = other**	**Th = throbbing**



Functional Rating Index

For use with Neck and/or Back Problems only.
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ Total Score _____
PRINTED

_____ _____
Signature Date