Bluffton Family Chiropractic

Patient Introduction

Name: ______________________________ Preferred Name: __________________

Age: _____ Date of Birth: ____________________ Circle: Male or Female

Telephone: Home:______________ Work: ______________ Cell: ______________

Email Address: ____

Address: ____

____

Occupation: ______________ Employer (previous if retired): _______________________

Do you have Health Insurance? Y N (Please bring insurance card to front desk.)

Marital Status: M S D W Ages of Children: ___________________________

Previous Chiropractor: ___________________________ City: ____________________

Last visit to this Chiropractor: __________ Reason for leaving: _______________________

Present MD: _________________________________ City: ___________________

Spouse's Information (Please provide parent's information if patient is under 18)

Name: __________________ Date of Birth: _______ Employer: __________________

Referred to our office by: ________________________ Relationship: _____________

1. All visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. The film itself is the property of this office. X-rays may be checked out to another doctor's office, but must be returned within 2 weeks.
3. Your signature below acknowledges that you are aware of our HIPPA policies. Policies are available from the receptionist upon request.
4. Patients with Insurance: Your signature below authorizes the release of any medical or other information necessary to process your claim. It also authorizes payment of medical benefits directly to our office for services performed in this office.

____ ____________________

Patient's Signature (or guardian's signature if patient is under 18) Date

Following the example below, complete the chart: 1) List all of your health complaints and for each: 2) When the problem began 3) How often the problem occurs: Constantly, Frequently, Intermittently, Rarely 4) Rate pain on a scale of 0-10 (0 being no pain and 10 being excruciating) 5) What gives you temporary relief? 6) What makes it worse? 7) Was it caused by an accident (car or work)? 8) How does this interfere with your life (work, family, hobbies)?

1) Complaint	2) When it began	3) How often	4) Rate Pain	5) Temporary Relief	6) Worse	7) Accident?	8) Interferes with life
Example: Neck pain	2 weeks ago	Constantly	7	Ice, Rest	Lifting, Reading	No	Can't work, Can't lift children

What have you tried to get rid of these problems that did NOT work?______________________________

____

Have you become discouraged about handling these problems?________ Does handling these problems cause you stress?________________

On a scale of 1 to 10, with 10 being the highest, rate your commitment to helping us solve this problem: _____

Please list any accidents you have ever had:______________________________

____

Please list any medications you are taking and the reason for the medication:______________________________

____

Please list any serious illnesses, hospitalization or surgeries:______________________________

____

Do your children have any health problems that you are aware of?______________________________

Is there any other information you would like us to know?______________________________

____

Signature:______________________________ Date:____________________

For Women Only

Are you pregnant? Yes No Maybe Date of last menstrual cycle:__________________

Are you using any means of birth control medication (pill, patch, shots)?__________________

Do you experience severe cramping with your menstrual cycle or PMS?__________________

Are you experiencing any feritility issues?______________________________