FAIRWOOD
Chiropractic & Physical Therapy

## Patient Information

Date _____

Patient_____

Address_____

City_____ State_____ Zip_____

Sex: ❑ M ❑ F _____ Age _____

Birth date_____

❑Single ❑ Married

Occupation _____

Employer_____

Spouse's Name_____

Whom may we thank for referring you? _____

## Insurance

Who is Primary for this account? _____

Relationship to Patient _____

Insurance Co._____

Policy # _____

Is patient covered by additional insurance? ❑Yes No❑

Subscriber's Name_____

Birth date_____ _____

Relationship to Patient _____

Insurance Co._____

Policy # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the above listed insurance company (ies) and assign directly to Fairwood Chiropractic & Physical Therapy all insurance benefits, if any, other- wise 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 the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party Date

_____

Relationship to Insured

## Contact Information

Home:_____

Cell:_____

Email :_____

Emergency Contact:

Name:_____ Relationship:_____

Phone:_____ Phone2:_____

## Accident Information

Is condition due to an Auto or Work accident? ❑ Yes ❑ No

Date _____

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Worker Comp. ❑Other

Attorney Name (if applicable)_____

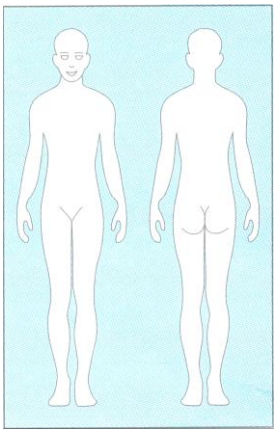
## Patient Condition

Health Problem/Reason For Visit_____

When did your symptoms appear?_____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting ❑Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

How often do you have this pain? ❑ Monthly ❑Bi-Monthly ❑Weekly ❑Daily ❑Other_____

Is it constant or does it come and go? _____

Does it interfere with your ❑ Work ❑ Sleep ❑Daily Routine ❑ Recreation

Activities or movements that are painful to perform:❑ Sitting ❑Standing ❑ Walking❑ Bending❑ Lying Down

# Health History

What treatment have you already received for your condition? ❑ Medications ❑ Surgery ❑ Physical Therapy
❑Chiropractic ❑ None ❑ Other _____

Name and address of other doctor(s) who have treated you for your condition?_____
_____

Date of Last: Physical Exam _____ Spinal X-Ray_____ Blood Test _____
Spinal Exam _____ MRI, CT-Scan_____
Primary Care Physician's Name _____

**Please mark each item below for each sign or symptom you presently have or previously had:**

**GENERAL SYMPTOMS**
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Nervousness
- ☐ Numbness
- ☐ Wheezing
- ☐ Depression

**MUSCLES & JOINTS**
- ☐ Swollen Joints
- ☐ Painful Joints
- ☐ Stiff Joints
- ☐ Sore Muscles
- ☐ Weak Muscles
- ☐ Walking Problems
- ☐ Broken Bones
- ☐ Arthritis

**CARDIO-VASCULAR**
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Poor Circulation
- ☐ Heart Trouble

**EAR/NOSE/THROAT**
- ☐ Earache
- ☐ Frequent Colds
- ☐ Hay Fever
- ☐ Nasal Blockage
- ☐ Nose Bleeds
- ☐ Pain Behind Eyes
- ☐ Sinusitis
- ☐ Sore Throats
- ☐ Tonsillitis

**GASTRO-INTESTINAL**
- ☐ Colon Problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Liver/Gallbladder
- ☐ Nausea
- ☐ Abdominal Pain
- ☐ Ulcer

**RESPIRATORY**
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Difficulty Breathing
- ☐ Spitting Blood

**GENITO-URINARY**
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Kidney Infection
- ☐ Painful Urination
- ☐ Prostate Problems

**SKIN OR ALLERGIES**
- ☐ Boils
- ☐ Bruising Easily
- ☐ Dryness
- ☐ Eczema/Rash/Dermatitis
- ☐ Allergy _____

**FOR WOMEN ONLY**
- ☐ Cramps/Backaches
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Miscarriage
- ☐ Painful Periods
- ☐ Breast Pain

❑ **Pregnant at this time?**

**Other**
_____
_____
_____

**Exercise Habits**
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

**Work Activity**
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

**Habits**
- ☐ Smoking Packs/Day_____
- ☐ Alcohol Drinks/Week____
- ☐ Coffee/Caffeine Drinks Cups/Cans/Day___
- Stress Levels ☐ High ☐ Normal ☐ Low

| Injuries/Surgeries/Fractures | Description | Date/Year |
|---|---|---|
| | | |
| | | |

| MEDICATIONS | ALLERGIES | VITAMINS/ SUPPLEMENTS |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| Pharmacy Name: _____ | _____ | _____ |

# PATIENT CONSENT- PLEASE PRINT

Patients Name_____ Date of Birth_____

**INFORMED CONSENT FOR CHIROPRACTIC CARE AND X-RAYS**

A patient in coming to the chiropractor gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, x-rays, diagnosis, and analysis. The Chiropractic adjustment or other clinical procedures are beneficial and extremely rarely cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury, please inform the doctor of any abnormalities. The doctor will not give a chiropractic adjustment or other health care if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the chiropractor. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Chiropractor provides a specialized non-duplicating health care service.

I hereby authorize an office evaluation and x-rays if necessary and verbally consented to, to be performed. Should I choose to become a patient in this Chiropractic office, I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to my physician.

Patient Signature _____ Date_____

Parent Signature for Minor_____ Date_____

**Attention Females Pregnancy Release**:
This is to certify that to the best of my knowledge I am not pregnant and the Doctor and his/her associates have my permission to perform x-rays. I have been advised that x-rays can be hazardous to an unborn child.
Date of last menstrual period._____

## Acknowledgement of Receipt

By signing this form, I acknowledge that I received or was offered the Privacy Notice and understand that my protected health information may be used by Fairwood Chiropractic and Physical Therapy as described in the Notice.

I,_____, hereby authorize Fairwood Chiropractic and Physical Therapy to release private medical information to or discuss my care with the following person(s). (Example: spouse, child, power-of-attorney, caretaker, family member)

_____ _____

_____ _____

_____ _____ _____ _____

Patient Signature Date Signature of Authorized Representative Date