

CHIROPRACTIC PATIENT UPDATE

Please complete Parts A & C in all cases. Part B should be completed only if the information has changed since you were last in our office.

Thank You!

PART A

Name: _____ Phone: _____

E-mail address: _____ Fax # _____ Cell Phone _____

Address: _____

Purpose of this appointment: _____

Is this the same problem you were originally under care for? Yes No

If yes, are there any additional symptoms? _____

Other doctors seen for this condition: _____

What medications or drugs are you taking? _____

PART B

Occupation: _____ Employer: _____

Employer's address: _____ Work Phone: _____

Spouse: _____ Spouse's Employer: _____

PART C

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that a \$10.00 past due fee is charged each month on overdue accounts.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

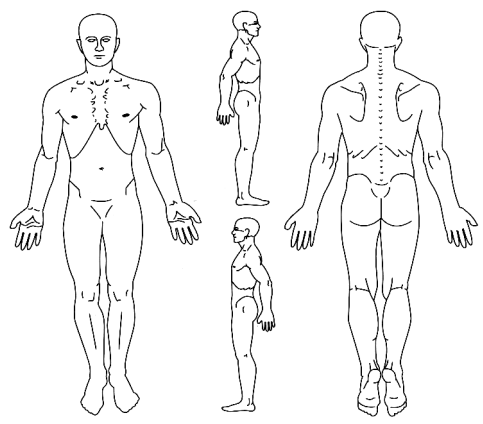
Date Signed: _____ Signature: _____

Health Insurance Coverage Yes No

Company: _____

1. What is your major symptom? _____
2. If this is a recurrence, when was the first time you noticed this problem? _____
 How did it originally occur? _____
 Has it become worse recently? Yes No Same Better Gradually Worse
 If yes, when and how? _____
3. How frequent is the condition? Constant Daily Intermittent Night Only
 How long does it last? All Day Few Hours Minutes
4. Do you have any other conditions or symptoms that you feel may be related to your major symptom? No Yes
 If yes, describe: _____
 Are there other unrelated health problems? No Yes, describe _____
5. Describe the pain. Sharp Dull Numbness Tingling Aching Burning Stabbing Other: _____
6. Is there anything you can do to relieve the symptoms? Yes No
 If yes, describe: _____
 If no, what have you tried to do that has not helped? _____
7. What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting Other: _____
8. Have you had any broken bones? No Yes If yes, please list and give dates: _____
9. List any major accidents you have had other than those that may be mentioned above. _____

10. To your knowledge, have you had any diseases, major illnesses, or injuries in the past or the present that are not indicated on this form? No Yes, describe: _____
11. **WOMEN ONLY:** Are you pregnant or is there any possibility that you may be pregnant? Yes No Uncertain
12. Please mark the location of your symptoms in the appropriate areas on the images below.



13. On the line below, please draw an "X" to indicate level of problem.

no symptoms unbearable symptoms

Doctor's Signature _____ Date _____
 West Omaha Chiropractic