PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

___Broken or Fractured Bones	___Osteoarthritis	___Eating Disorder	___Circulatory Problems
___Epilepsy	___Alcoholism	___Rheumatoid Arthritis	___Pace Maker
___Seizures/Convulsions	___Strokes	___HIV Positive	___A Congenital Disease
___Cancer	___Gall Bladder	___Excessive bleeding	___Ruptures
___Depression	___High/Low Blood Pressure	___Coughing Blood	___Ulcers

SOCIAL HISTORY

- Do you drink alcoholic beverages:_____ If so, how much per week:__________Do you smoke_________
- If so, how many packs per day:_______ Do you consume caffeine:______ If so, how much per day:______
- Do you exercise:_____ If yes, what is the frequency and type of exercise:_________________________
- What percentage of time during the day (at home or at your job away from home) do you spend:
- Lifting_________ Sitting_________Bending_________Working at a computer____________________

FAMILY HISTORY

FAMILY DISEASES (Check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister or **B**rother):

___Tuberculosis	___Cancer	___Mental Illness	___Diabetes
___Asthma	___Asthma	___Heart Disease	___Stroke
___Kidney Disease	___Lung Disease	___Arthritis	___Liver Disease

Other:____

Please check any and all insurance coverage that may be applicable in this case:

Major Medical   Worker's Compensation   Medicaid   Medicare   Auto Accident
Medical Savings Account & Flex Plans   Other

Name of Primary Insurance Company:____

Name of Secondary Insurance Company (if any):_______________________________________

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 cost 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.

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 there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:____Date:________________

Gurardian's Signature Authorizing
Care:______________________________**Date:**_______________________________________

PLEASE DO NOT WRITE BELOW THIS LINE

DOCTORS
NOTES:____

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