Date ______________________

Personal History Form

The following is a confidential questionnaire which will help us determine the best possible course of treatment for you. Please take your time and complete the information accurately. Thank you!

Name ____ S.S.# ___________________________

Address _______________________________________ City _______________ State _____ Zip ____________

Home phone ___________________________________ Business phone ______________________________

Cell phone _____________________________________ e-mail address _______________________________

Gender: ☐ Male ☐ Female Birth Date _________________ Age _________

Employer ______________________________________ Occupation __________________________________

Employment address ____

In case of emergency contact _________________________________ Phone __________________________

Referred by _________________________ Have you ever been treated by a chiropractor before? ☐ Yes ☐ No

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How would you describe your chief complaint at this time?

____

____

When did it start? ____
(Include month and year, day if known)

What makes the pain worse? ____

What makes the pain better? ____

How would you describe your pain? ____

At what time of the day or week is your pain worse? ____

The pain is: ☐ Intermittent ☐ Constant

Have you had this problem in the past? ______________ If so, how often? ______________________________

How many times a week do you engage in physical activity that is sufficiently prolonged and intense to cause sweating and raise you heart rate?____

When you engage in the physical activity noted above, what is the average duration of activity?
____ Less than 10 minutes ____ 10 – 20 mins ____ 20 – 30 mins ____ 30 – 60 mins _____ over 60 mins

When you engage in the physical activity noted above, what do you feel the level of effort is?_________________

At work, how many days per week do you engage in tasks that are intense enough to cause sweating and a rapid heart rate?____

Please rate your level of fitness (0 = very poor, 5 = average, 10 = excellent) ______________________________

Is your pain the result of a motor vehicle accident? ______________________________

Have you filed a legal suit? ______________________________

Is your pain the result of a work related injury? ______________________________

If so, have you filed a worker's compensation claim? ______________________________

Please list accidents, injuries, surgeries, and hospitalizations you have had.

______________________________ Date or Age ____________

______________________________ Date or Age ____________

______________________________ Date or Age ____________

Do you or other family members have a history of any of the following?

Arthritis	☐ Self	Family member ____________
Asthma	☐ Self	Family member ____________
Cancer	☐ Self	Family member ____________
Diabetes	☐ Self	Family member ____________
Heart Disease	☐ Self	Family member ____________
Hypertension	☐ Self	Family member ____________
Hypoglycemia	☐ Self	Family member ____________
Kidney Disease	☐ Self	Family member ____________
Depression	☐ Self	Family member ____________
Mental Illness	☐ Self	Family member ____________

Do you drink coffee or black tea? ____________ If so, how much per day? ____________

Do you smoke tobacco? ____________ If so, how much per day? ____________

Do you drink alcohol? ____________ If so, how often? ____________

What medications, vitamins, supplements, herbs do you take?

Name	**Reason**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Please list any allergies that you have.

____

Consent to Chiropractic Services

I, ____, authorize the performance upon myself of the following procedures:

A. Chiropractic Manipulation Treatment, CMT
B. Soft tissue/joint therapy
C. Physiotherapy
D. Physical Therapy
E. Exercise/Training

I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unknown conditions, that Dr. Chad Eldridge, DC may consider necessary or advisable in the course of my health care.

The nature and purpose of the procedures, possible alternatives, and the risks involved, the possible consequences, and the possibility of complications have been explained to my satisfaction by Dr. Chad Eldridge, DC.

I acknowledge that no guarantee or assurance of the results that may be obtained from the procedure has been given by Dr. Chad Eldridge, DC,

Date:_______________ Patient Signature:__________________________________

HIPPAA Patient Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. 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. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company provided to us by the patient for the purpose of payment. Be assured that this office will limit release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy policy has been designed to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those whom do not need them.
6. If the patient refuses to sign this consent for the purposes of treatment, payment, and health care operations, the chiropractic physician has the right to refuse care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Date:________________ Patient Signature:_______________________________________