

New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data			
First Name	Last Name	Date	Email*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.			

Mailing address			
Address	City	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone (Work)	(home)	Referred By	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Age	Birth Date	Social Security #	Number of Children
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Occupation	Employer		
<input type="text"/>	<input type="text"/>		
Marital Status	Spouse's Name	Spouse's Occupation	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Spouse's Employer	Spouse's Health Status		
<input type="text"/>	<input type="text"/>		
Emergency Contact	Phone		
<input type="text"/>	<input type="text"/>		

Current Complaints			
Nature of Injury: <input type="checkbox"/> Automobile* <input type="checkbox"/> Work <input type="checkbox"/> Other			
Please describe: <input style="width: 100%;" type="text"/>			
Date of Injury	Date symptoms appeared		
<input type="text"/>	<input type="text"/>		
Have you ever had same condition? <input type="radio"/> No <input type="radio"/> Yes If yes, when? <input style="width: 150px;" type="text"/>			
List of other practitioners seen for this injury/condition <input style="width: 100%;" type="text"/>			
Have you ever been under chiropractic care? <input type="radio"/> No <input type="radio"/> Yes			
If yes, please describe <input style="width: 100%;" type="text"/>			

Insurance Information			
Name of party responsible for payment		Phone	
<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>	
Do you have health insurance? <input type="radio"/> No <input type="radio"/> Yes Name of company <input style="width: 150px;" type="text"/>			
* If an auto accident, please provide:			
Insurance Company Name		Contact Person	
<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>	
Phone:	Claim #		
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>		

Signatures	
Name of the insured _____	
I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.	
Patient's signature _____	Date _____
Spouse's or guardian's signature _____	Date _____



Medical History

Have you been treated for any conditions in the last year? No Yes

If yes, please describe

Date of last physical exam Is there a chance that you are pregnant? No Yes

Have you had X-rays taken? No Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc.)

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had Sprains/Strains?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had surgery?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	<input type="radio"/> No	<input type="radio"/> Yes
Do your symptoms interfere with daily life?	<input type="radio"/> No	<input type="radio"/> Yes
Does pain wake you up at night?	<input type="radio"/> No	<input type="radio"/> Yes
Are your symptoms worse during certain times of the day?	<input type="radio"/> No	<input type="radio"/> Yes
Do changes in weather affect your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes
Do you wear orthotics?	<input type="radio"/> No	<input type="radio"/> Yes
Do you take vitamin supplements?	<input type="radio"/> No	<input type="radio"/> Yes
What activities aggravate your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes

Habits	None	Light	Moderate	Heavy
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soft Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salty Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sugary Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial Sweeteners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

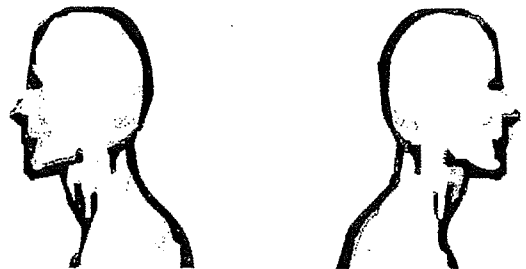
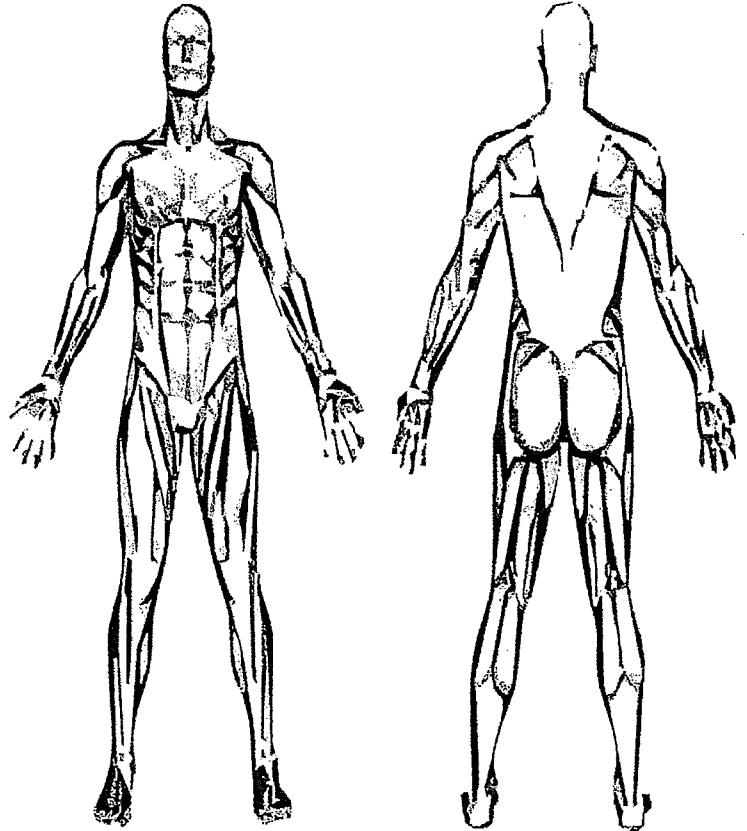


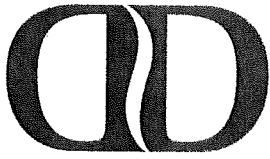
Have you ever suffered from:

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold Extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain or Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems or Insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache O=Other
 B=Burning P=Pins & Needles
 N=Numbness S=Stabbing





DR. DAN
CHIROPRACTIC & REHAB

CONSENT TO X-RAY

I hereby authorize Dr. Dan Fricke and any clinician authorized by Dr. Dan Fricke to take x-rays of myself (or said minor) if Dr. Dan deems it necessary for treatment due to my condition or the condition of said minor.

Dated this _____ day of _____, 20_____.

Patient Name:

Patient Signature:

Witness Name:

Witness Signature:

CONSENT TO TREATMENT OF A MINOR

I hereby authorize Dr. Dan Fricke or any clinician authorized by Dr. Dan Fricke to administer chiropractic care to my:

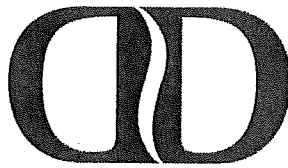
Indicate relationship to child: _____

Indicate Name of child: _____

Dated this _____ day of _____, 20_____.

Patient Signature:

Witness Signature:



**DR. DAN
CHIROPRACTIC & REHAB**

Consent for Use of Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health care information to another health care provider or to a hospital if it is necessary to refer you to them for a diagnosis, assessment, or treatment.
- We may have to disclose your health care information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.
- We may need to use your personal information to remind you of your appointments, send you a birthday card, send you a thank you for referrals, acknowledge your referral on an in office referral board, send you a welcome to the office information letter, invite you to participate in patient appreciation days, send you an official newsletter, or send promotional information.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to view that notice before you sign this consent form.

We reserve the right to change our privacy practices as described in that notice. If we make any change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding upon us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest to any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

Print Name

Authorized Provider Representative

Signature

Date

Date



Auto Accident Information

Patient Name: _____ Date: _____

Date and time of accident: _____ a.m. p.m.

Were you the: Driver Front Passenger Rear passenger

Make and model of the vehicle you were occupying? _____

If a traffic violation was issued, to whom was it issued? _____

Number of people in accident vehicle? _____

Did the police come to the accident site? Yes No

Was a police report filed? Yes No

Were there any witnesses? Yes No

Were you wearing a seat belt? Yes No

Was this vehicle equipped with airbags? Yes No

If yes, did it/ they inflate? Yes No

In relation to the base of your skull, where was the headrest? Above Below At base of skull

What did your vehicle impact? Another vehicle Other

If other, explain: _____

Did any part of your body strike anything in the vehicle? Yes No

If yes, please describe: _____

Make and model of the vehicle you were occupying? _____

Name of the location/ street on which you were traveling? _____

In which direction were you headed? N S E W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the : Front Rear Right Side Left Side Other

During impact, were you facing: Right Left Forward

Were you aware or surprised by the impact?

If accident vehicle made impact with another vehicle...

Direction other vehicle was headed? N S E W

Approximate Speed of the other vehicle? _____

In your words, please describe the accident:

Patient Name _____

Date _____

After Injury

Did accident render you unconscious? Yes No

If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital or seen any other Doctor? Yes No

When did you go? Just after accident The next day 2 days plus

How did you get there? Ambulance Private transportation

Name of hospital and/ or attending doctor: _____

Was he/she a: D.C. M.D. D.O. D.D.S

Describe any treatment you received: _____

Were X-Rays taken? Yes No

Was medication prescribed? Yes No

Have you been able to work since this injury? Yes No

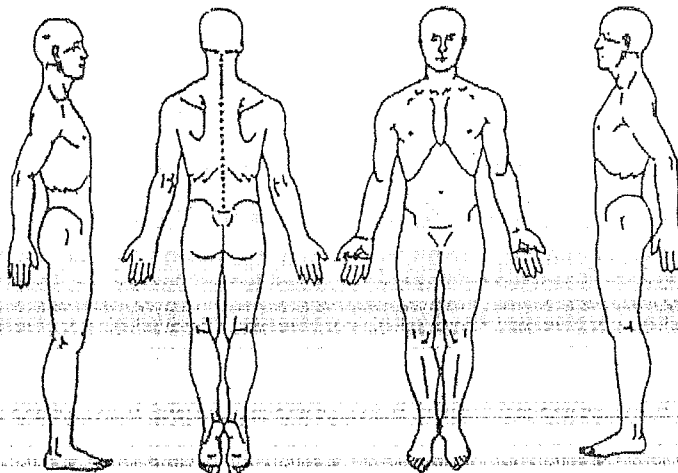
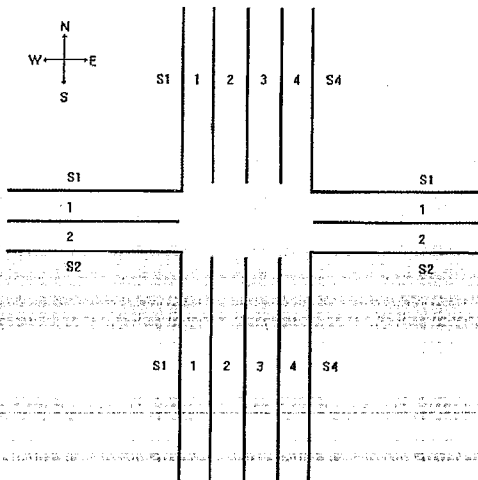
Are your work activities restricted as a result of this injury? Yes No

Indicate the symptoms that are a result of this accident:

- Dizziness
- Memory loss
- Headache(s)
- Blurred vision
- Buzzing in ear
- Ears ringing
- Difficulty Sleeping
- Irritability
- Fatigue
- Tension
- Neck pain
- Neck stiff
- Jaw problems
- Arms/ shoulder pain
- Numb hands/ fingers
- Chest pain
- Shortness of breath
- Stomach upset
- Nausea
- Back pain
- Lower back pain
- Back stiffness
- Leg pain
- Numb feet/ toes

Other _____

Is your condition getting worse? Yes No Constant Comes and goes



Please draw the accident as it happened

Please indicate areas of pain in diagram above



Patient Name _____

Date _____

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lovemaking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you retained an attorney: Yes No

If yes, whom? _____

His/ Her phone #: _____

Recovery

How many hours are in your normal workday? _____

Please indicate on your daily job duties and any activities, which you are occasionally asked to perform.

<input type="checkbox"/> Standing	<input type="checkbox"/> Driving	<input type="checkbox"/> Operating equipment
<input type="checkbox"/> Sitting	<input type="checkbox"/> Twisting	<input type="checkbox"/> Work with arms above
<input type="checkbox"/> Walking	<input type="checkbox"/> Crawling	head
<input type="checkbox"/> Lifting	<input type="checkbox"/> Bending	<input type="checkbox"/> Typing
		<input type="checkbox"/> Stooping

Other _____



DR. DAN
CHIROPRACTIC & REHAB

Patient Name _____

Date _____

What positions can you work in with minimum physical effort and for how long?

_____ N/A

Prior to the injury were you capable of working on an equal basis with others your age? Yes No N/A

Do you work with others who can help you with any heavy lifting? Yes No N/A

While in recovery, is there any light duty work you could request? Yes No N/A

- o We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- o Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- o I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- o I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____

Date ____/____/____

Adult patient Parent or Guardian Spouse