Today's Date: _____/_____/_____

Welcome to Chapman Chiropractic! Your medical history is a key component to providing you with the most thorough and comprehensive care possible. Please follow the instructions below and fill out all forms to the best of your ability.

Patient Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss

First Name: _____

Last Name: _____ **Middle Initial:** _____ **Suffix:** _____

Date of Birth: _____/ _____/ _____ **Gender:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Other

Is the patient a minor ☐ Yes ☐ No

If **Yes:** Name of Guardian completing form: _____

Relationship to patient: _____

Address: _____

Secondary Address (If applicable): _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ **Secondary Phone:** _____

Primary Email: _____

Primary Care Provider: _____

Employment Status (Check One)

☐ Employed ☐ Self Employed ☐ Retired ☐ Student ☐ Other

Employer/Company Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

Job Description: _____

Preferred Language (Other than English) _____

Insurance Information

Subscriber's Name: _____ Date of Birth: _____

Subscriber's Address: _____

Relationship to Patient (If not the patient):_____

Insurance Company: _____ Policy Number: _____

Secondary Insurance: _____ Policy Number: _____

Please List All Current Medications (Include all prescriptions, over-the-counter, and supplements as well as frequency and dosage if known) or **I currently do not take any medications** ☐

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list any known **Allergies to Medications:**

1. _____
2. _____
3. _____
4. _____

Other known **Allergies:** _____

_____

Do you use tobacco of any kind? ☐ Yes ☐ No ☐ Former Tobacco User

If yes, how often do you use tobacco/frequency? _____

Please check the boxes if you have or previously had any of the listed conditions:

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Poor Circulation
- ☐ Angina (chest pain)
- ☐ Excessive Bleeding

Endocrine

- ☐ Thyroid Issues
- ☐ Immune Disorders
- ☐ Hypoglycemia
- ☐ Diabetes
- ☐ Swollen Glands
- ☐ Low Energy

Respiratory

- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Emphysema
- ☐ Hay Fever
- ☐ Shortness of Breath
- ☐ Pneumonia

Please check the boxes if you have or previously had any of the listed conditions:

Musculoskeletal

- Osteoporosis
- Arthritis
- Scoliosis
- Hip Disorders
- Knee Injuries
- Elbow/Wrist Pain
- TMJ Issues
- Foot/Ankle Pain
- Shoulder Problems

Neurological

- Anxiety
- Depression
- Headaches/Migraines
- Dizziness
- Fainting
- Pins and Needles
- Numbness

Digestive

- Ulcers
- Heartburn
- Constipation
- Diarrhea
- Food Sensitivities

Genitourinary

- Kidney Stones
- Prostate Issues
- Infertility
- Erectile Dysfunction

Sensory

- Blurred Vision
- Ringing Ears
- Hearing Loss
- Loss of Smell
- Loss of Taste
- Chronic Ear Infections

Integumentary

- Skin Cancer
- Psoriasis
- Eczema
- Acne

- History of Cancer

Type: _____

Year Diagnosed: _____

Do you have any other medical conditions not listed above? Yes No

If Yes please list: _____

Family History: Health Condition or Illness

Mother: _____

Father: _____

Brother(s): _____

Sister(s): _____

Please List date(s) and reason(s) for any hospitalizations:

Please list any surgical procedures you have had and date of procedure:

Please list any injuries not described above:

What is the reason for your visit today? _____

_____

Please describe any symptoms you are experiencing today? _____

_____

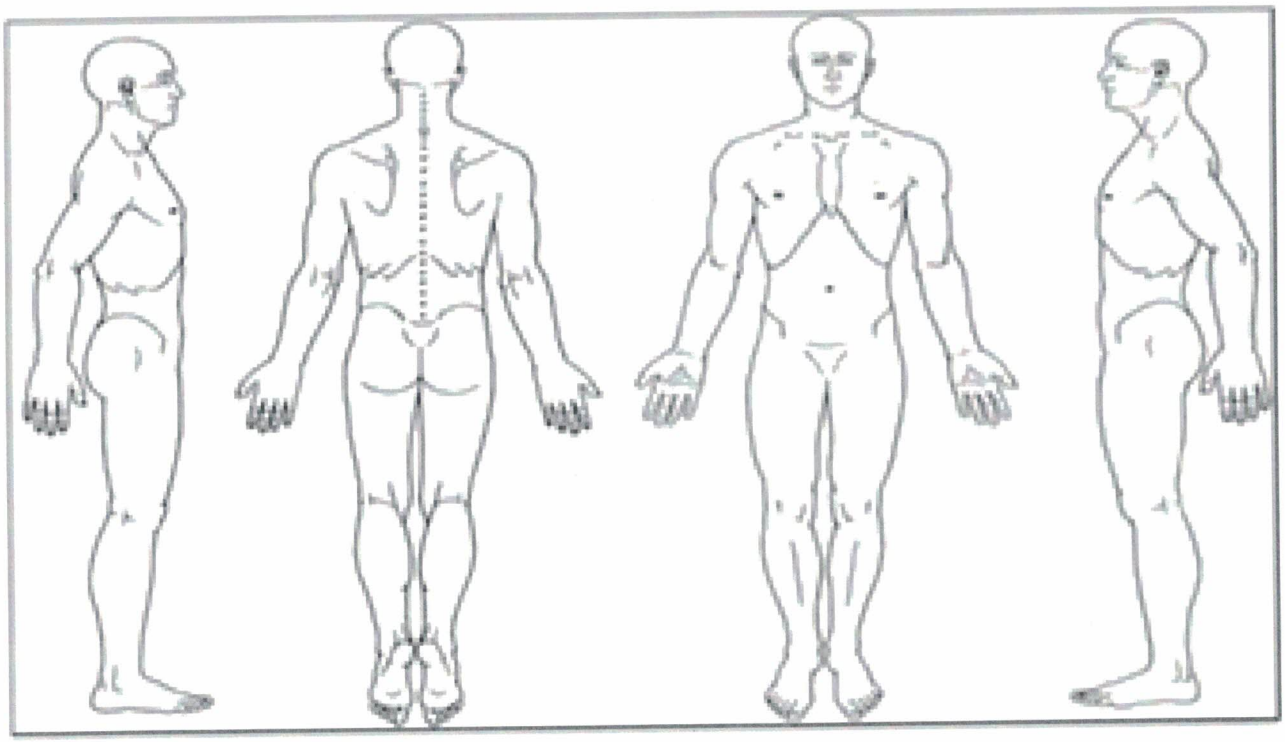
When and how did you symptoms begin? _____

_____

Please place an X on the diagrams below on the areas where you are experiencing discomfort.

Please draw an arrow in the direction of the pain if it radiates.

On a scale of 1 to 10, 1 being the least amount of pain and 10 being the worst amount of pain, what would you rate your pain today? _____



I have filled in and answered all questions honestly and to the best of my knowledge

Signature: _____.

INFORMED CONSENT FOR TREATMENT AND PAYMENT

Patient's Name: _____ Date:_____

I have received information from my doctor about my condition and proposed chiropractic treatment, including the anticipated benefits, the reasonably foreseeable risks and side effects of the treatment, and alternatives to the proposed treatment, including no treatment. Treatments include (but are not limited to):

Chiropractic Adjustment/Manipulation Instrument Assisted Adjusting/Activator

Cryotherapy/Ice Pack Exercise/Stretching Hot Moist Pack (HMP)

Instrument Assisted Soft Tissue Massage (IASTM) Manual Soft Tissue Massage

I understand that, as in all health care, there are some risks to chiropractic treatment. The risks include, but are not limited to bruising, soreness, worsening of symptoms, muscle strains, sprains, fractures, dislocations, and disc injuries. I do not expect the doctor to be able to anticipate and explain all risks, complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at this time, based upon the facts then known to him, is in my best interest.

I have had the opportunity to ask questions about my condition and the recommended care, and my doctor has answered all questions to my satisfaction. I understand that I may ask further questions at any time.

Patient/Guardian Signature:_____

Consent For Billing:

I am aware that Chapman Chiropractic has the right to bill me what my insurance does not cover. If I am a self pay patient, I am aware that I owe full payment for my appointment. I am aware that I am fully responsible to pay any bills sent to me by Chapman Chiropractic within the time frame indicated on my bill. I am aware that if I refuse to pay my bill, Chapman Chiropractic has the right to dismiss me as a patient.

Patient/Guardian Signature:_____

Doctor's Signature: _____

HIPAA Release Form

I acknowledge and understand that Chapman Chiropractic will not release any of my personal information without my prior consent. I reserve the right to decline the release of my records at any time and understand that I will be asked to sign a declination at that time.

Patient Name (Printed): _____

Patient Signature: _____

Today's Date: _____