Patient Information

Last Name:_____ First Name:_____ Middle Initial _____

Social Security: _____-_____-_____ Street Address:_____ Apt #: _____

City: _____ State: _____ Zip: _____

Patients Birthdate:_____ Weight: _____ Sex: M F

Home Phone: _____ Cell: _____

E-mail address: _____ Circle One: Married Single Widowed Divorced

Employer: _____ Occupation:_____

In Case of Emergency Please Contact. _____

Dr. Vance's Family Chiropractic Does Not File insurance. However if you would like a form to send to your insurance company for reimbursement. Please fill out the next sections.

Primary Insurance: Y N (If no continue to next section)

Insurance Company: _____

Primary Account Holder: Last name:_____ First Name: _____

Street Address:_____ Apt #: _____

City: _____ State: _____ Zip: _____

Social Security: _____-_____-_____ Birthdate: _____ Sex: M F

Home Phone: _____ Cell: _____

E-mail Address: _____

Secondary Insurance: Y N (If no continue to next section)

Insurance Company: _____

Primary Account Holder: Last name:_____ First Name: _____

Street Address:_____ Apt #: _____

City: _____ State: _____ Zip: _____

Social Security: _____-_____-_____ Birthdate: _____ Sex: M F

Home Phone: _____ Cell: _____ E-mail Address: _____

Please describe your condition(s) beginning with the most severe.

1._____ 2._____ 3._____

4._____ 5._____ 6._____

When did this/these conditions begin? _____

What do you think caused your condition? _____

What makes your condition (circle one) BETTER WORSE? _____

Have you seen anyone else for this condition? _____

Have you ever been treated by another chiropractor? _____

Has this ever happened before? YES NO When: _____

Please list your family physician, location (city and state), & medications you are currently taking:

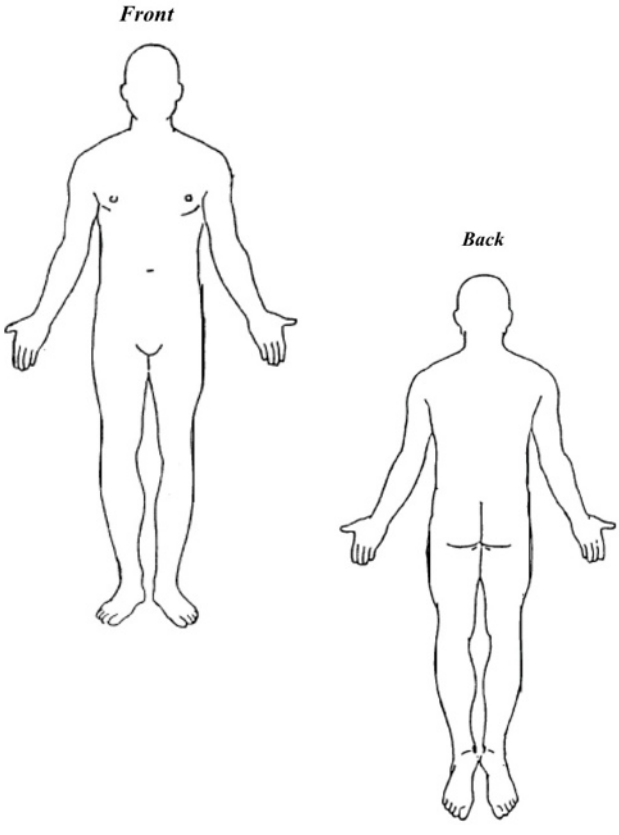
_____

Please list your complete surgical history (give dates and type of surgery):

_____

Please check the spaces for other symptoms you **are currently having** or **have had in the past**.
Please mark on the diagram where your pain is.

___ Headaches
___ Nausea
___ Diabetes
___ Upper Back Pain
___ Hand Tremors
___ Numbness or Tingling
___ Mid Back Pain
___ Nervousness
___ Leg or Foot Pain
___ Hearing Problems
___ Speech Difficulty
___ Chest Pain
___ Difficult Breathing
___ Irritability
___ Arthritis
___ Stroke
___ Anxiety
___ Dizziness
___ Neck Pain
___ Female Problems
___ Shoulder Pain
___ Arm and Hand Pain
___ Memory Loss
___ Low Back Pain
___ Hip or Buttock Pain
___ Sweaty Palms
___ Vision Problems
___ Allergies
___ Depression
___ Bowel/ Bladder Control
___ Prostate Problems
___ Bursitis
___ Cold hands/feet



For your presenting problems. Please identify all facilities/providers you have seen for these conditions and those you are seeing, if any.

Dr. Name/Facility	Problem	Type of treatment received	From When to When

Systems Review
For Dr. Vance only

____ General *	Weight changes, fatigue, anorexia, weakness, fever, chills changed in activity.
____ Skin*	Rashes, eruptions, changes in warts or moles, pigmentation changes, bruising, itching, hair loss, nail changes
____ Head*	Trauma, headaches, dizziness, light headedness
____ Eyes	change in acuity of vision, use of corrective lenses, loss of vision, diploipic, photophobia, blurred vision, scolomata, pain excessive lacrimation, redness, discharge.
____ Nose	Rhinorrhea, epistaxis, allergies, airway obstruction.
____ Mouth & Throat	Ulcers, tooth pain, extractions, temporomandibular joint pain, gum bleeding soreness, swelling, enlarged glands, sore throat, strep throat.
____ Neck*	Stiffness, lumps/swelling/ masses, pain
____ Lungs	Cough (productive/nonproductive), hemoptysia, dyspnea, pain with respiration, wheezing, night sweats.
____ Cardiac	palpitations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope.
____ Vascular	Raynaud's phenomenon, intermittent claudication, hyper-tension, rheumatic fever.
____ Breasts	Self-examination frequency/results, pain, nipple discharge, lumps, masses, skin dimpling.
____ Gastrointestinal	Unusual diet, dysphagia, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematernasis, stool color changes, diarrhea, constipation, change in bowel habits, jaundice, abdominal swelling.
____ Genitourinary	Plyuria, nocturia, oligun, dysuria, urgency/incontinence, urine color changes,hematuria, sexually transmitted diseases, dyspareunia, scrotal mass (male) hernia.
____ Endocrine	Polydipsia, polyphagia, temerature intolerance tremors, goiter, alopecia, menstruation history, pregnancy history, dysmenorhea, pre/menstrual syndrome, climacteric
____ Hematopoletic	Anemia, abdominal bleeding, lymph node enlargement/ pain.
____ Musculoskeletal*	Bone/joint pain, selling joint deformity, trauma, restricted range of motion, weakness, atrophy.
____ Neurological*	Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, stasis, loss of balance, numbness, paresthesia
____ Psychological	Mood swings, depression anxiety, phobias

Appointment Reminders and Health Care Information

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. By signing this form, you are giving us authorization to contact you through all forms of contact with these reminders and information.

Your may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. 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. In addition, 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 an of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of March 23, 2010. this authorization will expire seven years after the date on which you received services from us.

I authorize you to use or disclose my health information in the manner described above. I am acknowledging that I have received a copy of the authorization.

X _____ _____

Patients Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have provided with a notice of information practices that provides a more complete description of information uses and disclosures. I understand that I have the following privileges.

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

X _____ _____

Patients Signature Date

I hereby authorize Dr. Vance's Family Chiropractic to examine me, including the referral of x-rays if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. By signing below, you certify the accuracy of your medicat and/or accident history and further certify that you present to Dr.

X _____ _____

Patients Signature Date