

SHEPARD FAMILY CHIROPRACTIC
CONFIDENTIAL PATIENT INFORMATION

Name _____ Social Security

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 Date _____
Address _____ Home Phone (____) _____
City _____ Zip Code _____ Email _____ Work Phone (____) _____
Age _____ Birth Date _____ M F Marital: M S W D How Many Children? _____
Occupation _____ Employer _____
Address _____ Office Phone _____
Name of Spouse (or Parent if Minor) _____ Work Phone _____
Employer _____ Address _____
Name of Nearest Relative _____ Address _____ Phone _____
Whom may we thank for referring you? _____

Purpose of this appointment/current problem _____
Other doctors seen for this condition _____
Is the condition due to injury or sickness arising out of employment or auto accident? _____
Date symptoms appeared or accident happened: _____ Days lost from work? () YES () NO
Do you suffer from:
1. Dizziness _____ 5. Neck Pain _____ 9. Shoulder/ Arm Pain _____ 13. Nervousness _____
2. Back Pain _____ 6. Arthritis _____ 10. Hip/ Leg Pain _____ 14. Sinus Trouble _____
3. Heart Trouble _____ 7. Headaches _____ 11. Urinary Problems _____ 15. Male/ Female Troubles _____
4. Diabetes _____ 8. Numbness _____ 12. Digestive Disorders _____ 16. Cancer _____
Do you smoke? () NO () YES _____ packs/day Do you have a pacemaker? () YES () NO
Have you been treated for any health condition by a physician in the last year: () YES () NO
Describe _____
Date of last physical examination _____ List surgeries _____
Serious illnesses _____ Medications _____
What vitamins are you taking? _____
If female, are you taking birth control pills? () YES () NO Pregnant? () YES () NO

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION: By signing this form, you are granting consent to Shepard Family Chiropractic to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Patient Signature (or Guardian Signature Authorizing Care) _____ Date _____
Insurance Company _____ Insured _____ SS# _____

Patient Name _____ Date _____

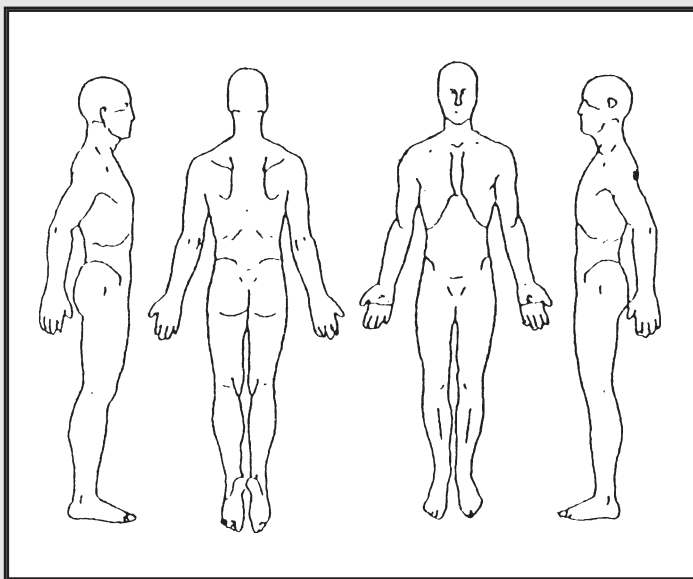
1. What is your major symptom? _____
2. When was the first time you noticed this problem? _____
How did it occur? _____
Has it become worse recently? _____ If yes, when and how? _____
3. How frequent is the condition? _____
How long does it last? _____
4. Have you ever had the same or a similar condition: () Yes () No
If yes, when and describe: _____
5. Are there any conditions or symptoms you have that may be related to your major symptom?

6. If pain is involved, is it – sharp, dull, throbbing, stabbing, aching, burning, tingling, shooting?
(other) _____
7. Is there anything you can do which seems to provide relief? _____

8. What makes the problem worse? _____
9. List accidents, illness, surgeries, or broken bones. _____

IMPORTANT!

10. Please Mark Your Symptom Areas



11. Rate the Severity of Your Condition

