CHARLESTON Neck & Back CENTER

Confidential Patient Information

Patient Number _____

Please Print Clearly Today's Date _____

Patient Demographics

How did you FIRST hear about us? _____

Have you ever been treated by a chiropractor? □ Yes □ No, If yes, who _____

Have you ever been treated at Charleston Neck & Back Center? □ Yes □ No

Legal First Name | Middle | Legal Last Name | Preferred Name

Mailing Address | Apt. # | City | State | Zip

Home Phone | Cell Phone | Work Phone

Email Address (We will NOT share your email with any third party. We will only use your email to contact you in relation to your care with our practice.)

Male / Female
Gender (Circle one)

_____-_____-_____ Social Security # | _____/_____/_____ Date of Birth | Driver's License # | State

Marital Status | Spouse's Name | Number of Children

Emergency Contact

First Name | Last Name | Phone | Relationship

Employment Information

Employment Status | Employer Name | Occupation / Job Description

Address | City | State | Zip

Phone # | Fax #

Insurance Information

Personal Health Insurance Carrier | Health ID card # | Group #

Policy Holder's Name | _____/_____/_____ Policy Holder's Date of Birth | Policy Holder's Employer

Primary Care Physician

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

□ **I choose to decline to receive a clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____

Current Health Condition

Brief detailed description of the problem you are currently experiencing:

_____

_____

Is the Condition: ☐*Auto Related* ☐*Job Related* ☐*Home Injury* ☐*Slip or Fall*

☐*Lifting* ☐*Slept Wrong* ☐*Unknown Cause* ☐*Other* _____

_____/_____/_____ Date of Accident

_____/_____/_____ Condition/Pain STARTED on what date?

_____

Has this ever occurred before?

_____

Have you seen other doctors for THIS CONDITION? If yes, who? (Name)

_____

Type of Treatment received for THIS condition?

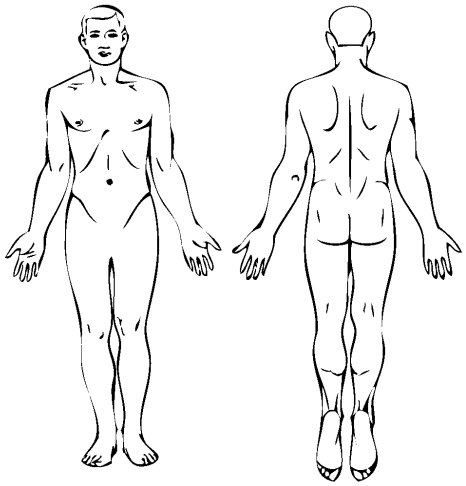
_____

Were you satisfied with the results of your treatment? Explain

LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

Use the letters below to indicate the
TYPE & LOCATION of your sensations right now.

Key: ***A=Ache B=Burning N=Numbness***
P=Pins & Needles S=Stabbing



Are you currently pregnant? ☐ **Yes** ☐ **No** If yes, how long have you been pregnant? _____

Do you have a pacemaker or implantable cardioverter-defibrillator (ICD)? ☐ **Yes** ☐ **No**

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

Do you have any medication allergies?

Medication	Reaction	Onset Date	Additional Comments

Do you SUFFER with ANY OTHER Condition than that which you are now consulting us?

_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

_____

Consent to treat a Minor Date

_____

Guardian or Spouse's Signature of Authorizing Care Date

_____

Patient (Print Name) Patient's Signature Date