



## 1. PATIENT INFORMATION

Today's Date \_\_\_\_\_

Full Name \_\_\_\_\_ SSN \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Gender:  M  F Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Race \_\_\_\_\_ Ethnicity: Hispanic or Latino / Not Hispanic or Latino / I decline to answer

Preferred Language \_\_\_\_\_ Occupation \_\_\_\_\_ Where Employed \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email: \_\_\_\_\_

Married  Single  Divorced  Separated  Widowed Spouse's Name \_\_\_\_\_

Preferred Method of Contact: Email | Phone | Mail Appointment Reminder: Text | Email | None

**Text Alerts** Carrier: \_\_\_\_\_

How soon before your appointment would you like to be alerted (please circle one choice)?

5 mins. | 10 mins. | 15 mins. | 30 mins. | 45 mins. | 1 hour | 2 hours | 4 hours | 1 day | 2 days | 1 week

How did you hear about us? (Please provide name of person, if applicable) \_\_\_\_\_

## 2. HEALTH HISTORY

1.  Yes  No Skin, hair or nail problems

2.  Yes  No Mouth and/or throat problems

3.  Yes  No Nose and/or sinus problems

4.  Yes  No Ear problems

5.  Yes  No Eye problems

6.  Yes  No Breathing problems

7.  Yes  No Smoke tobacco

Status: Every day smoker / Occasional smoker

Former smoker / Never smoked

Start Date (Optional): \_\_\_\_\_

8.  Yes  No Heart/blood vessel problems

9.  Yes  No Blood/lymph node problems

10.  Yes  No Digestive problems

11.  Yes  No Genital problems (e.g. prostate, testicular, vaginal)

12.  Yes  No Urinary problems (including kidney or bladder)

13.  Yes  No Mental health problems

14.  Yes  No Gland and/or hormone problems

15.  Yes  No Allergy or immunity problems

16.  Yes  No Muscle, tendon or ligament problems

17.  Yes  No Bone or joint diseases

## FEMALES--ADDITIONAL HEALTH HISTORY

18.  Yes  No Menstrual problems

19.  Yes  No Taken any form of birth control  
If yes, which type? \_\_\_\_\_

20.  Yes  No Currently pregnant.  
If yes, how far along are you? \_\_\_\_\_ weeks/months  
If yes, when was your last menstrual period? \_\_\_\_\_

21.  Yes  No Breast problems

### 3. PAST HISTORY

22. List all diseases that you have had in the past (including childhood diseases): \_\_\_\_\_  
\_\_\_\_\_

23. Have you ever been diagnosed with a particular condition such as diabetes, cancer, AIDS, etc.:  
\_\_\_\_\_

24. Have you ever suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones?

Yes  No If yes, describe accident including date of accident: \_\_\_\_\_  
\_\_\_\_\_

25. List all surgeries (including appendix, tonsils, ear tubes, wisdom teeth):

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

26. Have you ever been hospitalized for any reason other than surgery?  Yes  No

What? \_\_\_\_\_ When? \_\_\_\_\_

27. Medications: Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

28. Have you ever had cancer?  Yes  No If yes, describe: \_\_\_\_\_  
\_\_\_\_\_

### 4. FAMILY HISTORY

29. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases/conditions)?  Yes  No If yes, describe: \_\_\_\_\_  
\_\_\_\_\_

### 5. SOCIAL HISTORY

30. In what position do you usually sleep and how well? \_\_\_\_\_

31. Do you exercise on a regular basis?  Yes  No If yes, how? \_\_\_\_\_

32. How do you spend your spare time (hobbies, etc.)? \_\_\_\_\_

33. How would you describe your diet?  Balanced  Fair  Poor  Excessive  Restrictive

## SOCIAL HISTORY (cont'd)

34. Do you use:  Caffeine  Tobacco  Nicotine  Recreational Drugs  Alcohol

35. Describe your work (select all that apply):

Type: \_\_\_\_\_  Retired  Professional  Physical Labor  Driver  Athlete

Clerical  Factory  Homemaker  Student  Child

Physical Demands:  Heavy  Moderate  Mild  Sedentary

Stress Level:  High  Medium  Low

## 6. ADDITIONAL HISTORY

36. If there is any information about your health history that was not requested, please fill it in below: \_\_\_\_\_  
\_\_\_\_\_

37. Please describe your current complaint. In other words, what brought you here? Is it related to an accident or injury? \_\_\_\_\_

38. Who is your medical doctor? \_\_\_\_\_

39. Have you had any spinal imaging within the past year?  Yes  No If yes, where? \_\_\_\_\_

40. Have you ever seen a chiropractor before?  Yes  No If yes, date? \_\_\_\_\_

41. Have you ever seen a physical therapist before?  Yes  No If yes, date? \_\_\_\_\_

42. Have you had previous treatment(s) for your current condition? (check all that apply):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Physical Therapy     | <input type="checkbox"/> Biofeedback              | <input type="checkbox"/> Acupuncture                         |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Psychological Counseling | <input type="checkbox"/> Massage                             |
| <input type="checkbox"/> Chiropractic         | <input type="checkbox"/> Psychiatric Treatment    | <input type="checkbox"/> Trigger Point Injections            |
| <input type="checkbox"/> TENS                 | <input type="checkbox"/> Bed Rest                 | <input type="checkbox"/> Epidural or other spinal injections |

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

### NOTICE TO PATIENTS

We work hard to provide the best, most efficient and affordable chiropractic healthcare. In order to provide our high quality of service and efficiency we must keep our costs down. We work for you. However, we do reserve the right to dismiss you as a patient if you miss more than 3 appointments without prior notice. This arrangement will allow our office to maintain a level of service to each and every patient, as each patient counts on our quality and efficiency of service and care.

Requests by patients for x-rays will be processed in 24 hours. The patient is responsible for their x-rays once they are released from Runnels Chiropractic until they are returned.

# ASSIGNMENT OF BENEFITS FORM

Name of Policy Holder (print): \_\_\_\_\_

Social Security Number: \_\_\_\_\_

- Medicare is my primary insurance
- \_\_\_\_\_ is my primary insurance
- I am not seeking care in connection with an accident or injury

I request that payment of authorized insurance benefits (including Medicare, if I am a Medicare beneficiary) be made on my behalf to Runnels Chiropractic (the “**Provider**”) for any equipment or services provided to me by the Provider. I authorize the release of any medical or other information necessary to determine the extent of all benefits payable for related equipment or services on my behalf to (i) the Provider, (ii) the Centers for Medicare and Medicaid Services (“**CMS**”), (iii) my insurance carrier, (iv) or other medical entity. A copy of this authorization will be sent to CMS, my insurance company, or other entity if requested. The original authorization will be kept on file by the Provider. I understand that this assignment will remain in effect until revoked, in writing, by me.

I understand that I am financially responsible to the Provider for any charges not covered by healthcare benefits. It is my responsibility to notify the Provider of any changes in my healthcare coverage.

If I am a Medicare beneficiary, I understand that Medicare does not pay for exams, x-rays, physical therapy treatments, or maintenance treatments and that I am responsible for paying for these services out-of-pocket. I also authorize payment of all medical benefits that apply to all occasions for primary and supplemental (Medigap) coverage to be paid to the Provider.

In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the Provider and/or my healthcare insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting financial responsibility, as explained above, for all payment, equipment, and services provided by the Provider. I also understand that in the event it becomes necessary to employ a collection agency service to enforce payment under this Agreement/Contract, I agree to pay for collection costs and fees equal to fifty (50) percent of the delinquent balance associated with the collection thereof, including but not limited to, attorney’s fees and court costs. By signing this document, I also acknowledge that I have received a copy of the Provider’s Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Name of person signing below (print): \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

Signature of Insured or Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

## CONSENT FOR TREATMENT AND USE OF PROTECTED HEALTH INFORMATION

Chiropractors focus on dysfunctions that can result from irregularities of spinal structure or movement. Hands-on procedures are usually preferred by most chiropractors to determine structural and functional problems. Manipulation is used to promote normal bodily function thus correcting or preventing these structural deviations. Chiropractic "adjustment" refers to a variety of manual mechanical interventions. Chiropractic adjustments and other procedures are usually beneficial and seldom cause any harm to the patient. In most cases, there is gradual but satisfactory result from chiropractic treatment. Occasionally, the results are less than expected. In rare cases, however, unknown underlying defects, deformities, or pathologies may result in injury to the patient. I understand that results of chiropractic only treatment vary and I have disclosed all known latent pathological defects, illnesses, and deformities to my chiropractor.

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Signature

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Date

I consent to diagnosis and treatment options available to me and consent to receive services from Runnels Chiropractic ("the Practice").

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Signature

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Date

I consent the Practice to use the following methods to remind me of my appointments: a postcard mailed to my address, a message left on the voicemail of any telephone number provided by me to the Practice, a text message to the cell phone number provided by me to the Practice, or a message left with any individual answering any telephone number provided by me to the Practice.

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Signature

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Date

I consent to having treatments performed in an open area, which may be visible to other patients. The Practice will accommodate any reasonable request to discuss matters in private with me.

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Signature

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Date