Family Chiropractic & Health Center, LLC

Patient Information:
Last Name:______________________________ First Name:__________________________ (M):_____________
Address:____ City:___________________________________
State:______________ Zip:___________ Birth Date:_____/_____/________ SS#______/______/___________
Home Phone:_____________________ Cell Phone:_____________________ Work Phone:__________________
Occupation:_________________________________ Employer:____
Your E-mail address:____
Spouse or Guardian:
Name:____ Employer:_____________________________________
Work Phone: ___________________ Birth Date:______/______/_________ SS#_____/______/___________
How were you referred to our office? (Please X one of the following)
____Friend, family member, or another patient, if so who_______________________so we can send them a thank you letter.
_____Phone book _____Office Sign _____ Attorney _____Another Physician _____Internet
_____Other ____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at our office? ☐ Yes ☐ No
If yes, can we have the name of your Family Medical Doctor:____
Have you ever been to a Chiropractor before? ☐ Yes ☐ No
If yes, for what and how long ago ____

Please X any and all Insurance coverage that may be applicable in this case:
☐ Major Medical (Blue Cross or other Health Insurance) ☐ Workman's Compensation
☐ Medicare ☐ Personal Injury (Attorney) ☐ Automobile Insurance Policy (MedPay)
☐ Check, Credit Card, and/or Cash

Name of Primary Insurance:____
Name of Secondary Insurance Company (if any):____

INSURANCE AUTHORIZATOIN AND RELEASE

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees or professional services will be immediately due and payable.

PRIVACY NOTICE

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the font desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

RECORDS RELEASE AUTHORITY

I,_______________________________, hereby request that __________________________________ provide:
_____a copy of the report for my MRI/CT scan and/or any other radiological tests
_____ a copy of all my medical notes pertinent to the treatment of my ____________________________to

_______Dr. Michael S. Horn
_______Dr. Michael S. Hitchner
At Family Chiropractic & Health Center.

Patient Signature:____ Date:_____/_____/________
Guardian's Signature Authorizing Care:____________________________ Date:_____/_____/________

Family Chiropractic & Health Center 1515 University Blvd. Tuscaloosa, AL 35401 (205)758-2225

CURRENT COMPLAINT HISTORY

PATIENT'S NAME:____

1. What is your Major Complaint (symptom, or reason for visit)? ____
2. Is this the first time you've ever had this problem? ↓

☐**Yes** If yes, when did it start? _________________________

☐**No** If no when was the first time you had it? ______________ and how did it occur originally?______________________

3. Is this episode the result of a ☐**Injury** ☐**Car Accident** ☐**Work Injury** ☐**None of the preceeding**
4. Have your symptoms become worse since they started? ↓

☐**Yes** If yes, how: ☐**more intense** ☐**more frequent** ☐**more area involved**

☐**No**

5. How frequent are the symptoms → ☐**Constant (24/7) or**

☐**Come & Go**↓

If it **comes & goes** does it bother you daily? ☐**Yes** ☐**No** When it bothers you how long does it last? ☐**Few Hours** or ☐**Minutes**

6. Describe some things that can make the problem worse. ____
7. Describe things that can relieve the problem (even temporarily): ____
8. Describe the pain: ☐Sharp ☐Aching ☐Burning ☐Stabbing ☐Dull ☐Numbness ☐Tingling Other: ___________
9. Please place an "X" on the line below to indicate the level of Pain (Symptoms)

No Symptoms ---Extreme Symptoms

10. Are there any others symptoms you are having that may or may not be related to the above problem? __________________

____

11. Have you had any major illnesses, injuries, falls, auto accidents or surgeries? ______________________________________

____

12. Have you been treated for a health condition by a physician in the past year? ☐**Yes** ☐**No** If yes, describe ________________

____

13. *For women only.* Are you pregnant or is there a possibility that you are pregnant? ☐**Yes** ☐**No**

14. Have you ever been diagnosed as having or have suffered from? (Check below if different than above)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder	__High/Low Blood Pressure
__Circulatory Problems	__Epilepsy	__Alcoholism	__Coughing Blood
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction	__Ulcers
__Seizures/Convulsions	__Strokes	__HIV Positive	__Excessive Bleeding
__Congenital Disease	__Cancer	__Gall Bladder	__Depression

List any medications you are taking. ____

______________________________________ /_____ /_____________

Patient's Signature Date