DeVries Family Chiropractic

Confidential Patient Information

Date_____

Name_____ Social Security ☐☐☐ ☐☐ ☐☐☐☐

Address_____ City _____

State_____ Zip Code_____ Email_____

Age_____ Date of Birth_____ ☐Male ☐Female Marital Status: M S W D

Home Phone _____Work Phone_____ Cell Phone_____

Children_____ Occupation_____ Employer_____

Address_____ Office Phone_____

Name of Spouse (or parent if minor) _____ Phone_____

Emergency Contact_____ Phone_____

Whom may we thank for referring you? _____

Purpose of this appointment/current problem _____

Other doctors seen for this condition _____

Is this condition due to injury arising out of employment or auto accident _____

Date symptoms appeared or accident occured_____Days lost from work___

Do you suffer from:

Dizziness _____	Neck Pain_____	Shoulder/Arm Pain_____	Nervousness_____
Back Pain_____	Arthritis_____	Hip/Leg Pain_____	Sinus Trouble_____
Heart Trouble_____	Headaches_____	Urinary Problems_____	Male/Female Trouble____
Diabetes_____	Numbness_____	Digestive Disorder_____	Cancer_____

Do you smoke( )NO ( )YES _____packs/day Do you have a pacemaker ( )NO ( )YES

Have you been treated for any health condition by a physician in the last year _____

Describe _____

Date of last physical exam_____ List medications_____

What vitamins are you taking_____

If female, are you taking birth control pills ( ) NO ( ) YES; Pregnant ( ) NO ( ) YES

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under 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 DeVries Family Chiropractic to use and disclose your protected health information for the purposes of treatment, payment and 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 the 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#_____

CONTINUED ON BACK

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: ( ) No ( ) YES
If yes, when and describe: _____

5. Are there any conditions or symptoms you have that may be related to your major symptom? _____

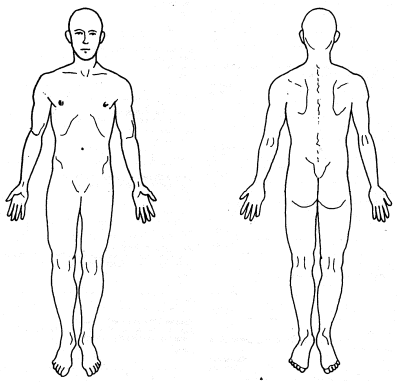
6. If pain is involved, is it – sharp, dull, throbbing, stabbing, aching, burning, tingling, shooting, (other)? _____

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_____
_____

10. Please mark your symptom areas:



11. Rate the Severity of your condition:

0____1____2____3____4____5____6____7____8____9____10
(None) (Stops all activity)