**PATIENT DEMOGRAPHICS**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Age: \_\_\_\_\_\_\_ 🞏 Male 🞏 Female

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work/Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: **🞎** Single **🞎** Married \_\_\_ Partnered \_\_\_ Widowed Do you have Insurance: **🞎** Yes **🞎** No

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of children and ages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you to this office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY of COMPLAINT**

Please identify the condition(s) that brought you to this office: Primary:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Third: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fourth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*:**

**Primary** or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Second** complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Third** complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Fourth** complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When is the problem at its worst? 🞏 AM 🞏 PM 🞏 mid-day 🞏 late PM

How long does it last? 🞏 It is constant **OR** 🞏 I experience it on and off during the day **OR** 🞏 It comes and goes

Did any of these complaints begin with an injury? Y or N If so , please describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has this condition(s) ever been treated by anyone in the past? 🞏No 🞏 Yes **If yes,** when: \_\_\_\_\_\_\_\_\_\_

by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long were you under care: \_\_\_\_\_\_\_\_\_\_\_\_

What were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Previous Chiropractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **🞎 N/A**

**PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

**R = R**adiating **B** **= B**urning **D =** **D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling

What makes your symptoms feel worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What relieves your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your problem the result of ANY type of accident? 🞏 Yes, 🞏 No

**PAST HISTORY**

Identify any other injury(s) to your spine, minor or major, that the doctor should know about: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have or **N** for ***Never*** have had**:** \_**\_\_** Broken Bone \_**\_\_**Dislocations **\_\_\_** Tumors \_**\_\_**Rheumatoid Arthritis \_\_\_ Fracture**\_\_\_\_**

Disability \_\_\_\_ Cancer \_\_\_\_ Heart Attack \_\_\_\_Osteo Arthritis \_\_\_\_Diabetes **\_\_\_\_** Cerebral Vascular

Other serious conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem**:

|  |
| --- |
| **HOW LONG AGO TYPE OF CARE RECEIVED BY WHOM** |
| **INJURIES 🡪** |
| **SURGERIES 🡪** |
| **CHILDHOOD DISEASES 🡪** |
| **ADULT DISEASES 🡪** |

**SOCIAL HISTORY**

**1. Smoking**: 🞎cigars 🞎 pipe 🞎 cigarettes How often? 🞎 Daily 🞎 Weekends 🞎 Occasionally 🞎 Never

**2. Alcoholic** **Beverage**: consumption occurs 🞎 Daily 🞎 Weekends 🞎 Occasionally 🞎 Never

**3. Recreational Drug use**: 🞎 Daily 🞎 Weekends 🞎 Occasionally 🞎 Never

**4. Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect? (See ADL form)

**FAMILY HISTORY**:

**1.** Does anyone in your family suffer with the same condition(s)? 🞎 No 🞎 Yes

**If yes whom**: 🞎 grandmother 🞎 grandfather 🞎 mother 🞎 father 🞎 sister(s) 🞎 brother(s) 🞎 son(s) 🞎 daughter(s)

Have they ever been treated for their condition? 🞎 No 🞎 Yes 🞎 I don’t know

**2. Any** other hereditary conditions the doctor should be aware of? 🞎 No 🞎 Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS**

Please mark: **P** for in the **Past** **C** for **Currently** have **N** for **Never**

\_\_\_ Headache \_\_\_ Pregnant (Now) \_\_\_ Dizziness \_\_\_ Prostate Problems \_\_\_ Ulcers

\_\_\_ Neck Pain \_\_\_ Frequent Colds/Flu \_\_\_ Loss of Balance \_\_\_ Impotence/Sexual Dys. \_\_\_ Heartburn

\_\_\_ Jaw Pain, TMJ \_\_\_ Convulsions/Epilepsy \_\_\_ Fainting \_\_\_ Digestive Problems \_\_\_ Heart Problem

\_\_\_ Shoulder Pain \_\_\_ Tremors \_\_\_ Double Vision \_\_\_ Colon Trouble \_\_\_ High Blood Pressure

\_\_\_ Upper Back Pain \_\_\_ Chest Pain \_\_\_ Blurred Vision \_\_\_ Diarrhea/Constipation \_\_\_ Low Blood Pressure

\_\_\_ Mid Back Pain \_\_\_ Pain w/Cough/Sneeze \_\_\_ Ringing in Ears \_\_\_ Menopausal Problems \_\_\_ Asthma

\_\_\_ Low Back Pain \_\_\_ Foot or Knee Problems \_\_\_ Hearing Loss \_\_\_ Menstrual Problem \_\_\_ Difficulty Breathing

\_\_\_ Hip Pain \_\_\_ Sinus/Drainage Problem \_\_\_ Depression \_\_\_ PMS \_\_\_ Lung Problems

\_\_\_ Back Curvature \_\_\_ Swollen/Painful Joints \_\_\_ Irritable \_\_\_ Bed Wetting \_\_\_ Kidney Trouble

\_\_\_ Scoliosis \_\_\_ Skin Problems \_\_\_ Mood Changes \_\_\_ Learning Disability \_\_\_ Gall Bladder Trouble

\_\_\_ Numb/Tingling arms, hands, fingers \_\_\_ ADD/ADHD \_\_\_ Eating Disorder \_\_\_ Liver Trouble

\_\_\_ Numb/Tingling legs, feet, toes \_\_\_ Allergies \_\_\_ Trouble Sleeping \_\_\_ Hepatitis (A,B,C)

**List Prescription & Non-Prescription drugs you take: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACTIVITIES OF LIFE**

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

**ACTIVITIES: EFFECT:**

Carrying or lifting ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Sit to Stand ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Climb Stairs ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Read/Concentrate ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Self-Care/Dressing ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Sexual Activities ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Sleep ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Static Sitting ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Static Standing ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Yard work ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Walking ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Household Chores ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Driving ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

**Privacy and Financial**

Consultation ………………………………………………………………………………………………...……... Free

New Patient Examination..…………………………………………………………………………….....…..$90

Radiographs (x-ray)……………………………………………………………………………………......…….$100

Spinal Adjustment……………………………………………………………….………………...................$42

Extremity Adjustment…………………………………………………………………………………………….$15

Re-examination after 12 visits.…………….………………………………………………...........….....$40

I have elected to use the following payment plan to finance my care at Taulman Chiropractic:

\_\_\_Cash/MasterCard/Visa/Discover – Payment is due at time of service.  Insurance Policy/HSA coverage – Although I am totally responsible for charges I may incur in this office. I will initially pay for my yearly deductible and co-payments for each visit. If my insurance fails to pay its share, I will be responsible for paying my balance in full. I will notify the front desk of any changes in policy coverage.

\_\_\_\_ Medicare/Medicare Replacement Plans – Payment is due at time of service. Taulman Chiropractic will assist in completing Medicare forms on my behalf. Medicare may only cover chiropractic adjustments for acute care.

\_\_\_\_Pre-Pay Plans Save $$$

\_\_\_\_Auto Accident/Workers Compensation

Note: Taulman Chiropractic will refund any overpayments made to us upon completion of care. The patient agrees that they are responsible for all bills incurred at this office, as well as court costs, attorney fees, and/or collection fees

I hereby authorize payment to be made directly to Taulman Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Taulman Chiropractic for any and all services I receive at this office. If collection costs are necessary, I understand that I am responsible for any and all fees. There is a $25 fee charged by the bank for any returned checks for non-sufficient funds.

Practice’s Privacy Requirements: The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. Additional information is available from the U.S. Department of Health and Human Services. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. It is our policy to remind patients of their appointments. We may do this by telephone, email, mail, or by any means convenient for the practice and/or as requested by you. We agree to provide patients with access to their records in accordance with state and federal laws. We may have to change, add, delete or modify any of these provisions to better serve the needs of both practice and patient. More information can be found and listed under our privacy practices. Please ask the staff for a copy and we will provide one to you.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date Office Signature Date Reviewed

