

W e l c o m e

Optimum health through chiropractic care

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Patient Information

Thank you for choosing our practice for your chiropractic needs.

Name _____ Date _____ S/S _____ - _____ - _____
Address _____ City _____ Zip _____
Sex: Female Male Birth date ____/____/____ Email: _____
Home Phone # _____ Work Phone # _____ Cell Phone # _____
Are you: Minor Married Divorced Widowed Single Domestic Partnership
Do you have children? _____ How many? _____
Your employer _____ Occupation _____
Business Address _____ City _____ Zip _____
Whom may we thank for referring you to us? _____
Person to contact in case of emergency _____ Phone # _____

Insurance Information

Name of insured _____ Relationship to patient _____
Insurance Co. _____ ID # _____ Group # _____
DO YOU HAVE ADDITIONAL INSURANCE? No Yes If yes, please complete the following:
Name of insured _____ Relationship to patient _____
Insurance Co. _____ ID # _____ Group # _____

Health History

Check only those conditions which are applicable:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Depression | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> STD |
| <input type="checkbox"/> Allergy Shot | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Migraine Headache | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Miscarriages | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Fractures | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gluten Intolerance | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gout | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> PID | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Polio | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herpes | <input type="checkbox"/> Prostate Problems | _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HPV | <input type="checkbox"/> Prosthesis | _____ |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Psychiatric Care | |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatoid Arthritis | |

WOMEN, are you pregnant? Yes, Due Date: _____ No

OB/GYN's name & phone number: _____

Allergies: _____

List any surgeries you have had and the dates: _____

List any medications you are taking: _____

Primary Care Physician's name & phone number: _____

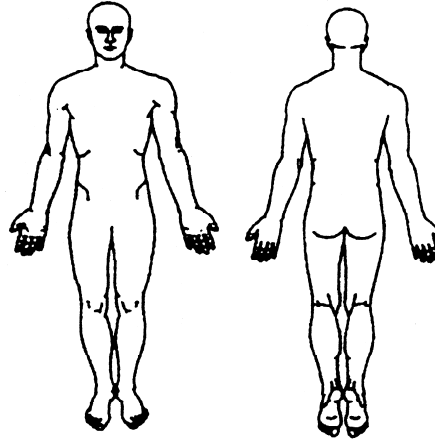
May we contact your Physician to discuss your case/records? Yes No

Symptoms

Reason for your visit _____ When did you first notice symptoms? _____

PLEASE MARK THE AREAS OF DISCOMFORT OR PAIN ON THE FIGURES BELOW USING THE SYMBOLS THAT BEST DESCRIBES THE FEELING:

- +++ Sharp or Stabbing
- ooo Pins and needles
- vvv Dull or aching
- /// Numbness



Rate the severity of your pain. (1: mild pain or discomfort, to 10: severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

Is this condition getting progressively worse? _____

Which activities are difficult to perform? Sitting Standing Walking Bending Other

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling Other

What treatment have you already received for your condition _____

Were X-rays taken? _____ If yes, what type of X-rays _____

Name the doctor who have treated you for this condition (s) _____

Have you seen a chiropractor before? _____ Date of last vist? _____

What condition were you being treated for? _____

Family History

Please indicate if members of your immediate family have/had any of the listed conditions.

PGM/PGF-Paternal Grandmother/Grandfather MGM/MGF-Maternal Grandmother/Grandfather

Arthritis: () Denied () Mother () Father () PGM () PGF () MGM () MGF () other _____

Heart Disease/Stroke: () Denied () Mother () Father () PGM () PGF () MGM () MGF () other _____

Cancers: () Denied () Mother () Father () PGM () PGF () MGM () MGF () other _____

Diabetes: () Denied () Mother () Father () PGM () PGF () MGM () MGF () other _____

Please describe any other Significant family history relevant to your condition: _____

Daily Habits

Do you participate in a regular exercise program? If so how often? _____

What type of exercise do you perform on a daily basis? None Moderate Heavy

What type of work do you do and what do daily work activities include? (ex. sitting, standing, light labor, heavy labor, computer work) _____

Any exposure to chemicals or toxic substances Yes No _____
Is work station ergonomic: Yes No _____
What vitamins do you currently take? _____
Do you smoke? _____ How much per day? _____
How much liquor do you consume on a weekly basis? _____
How much coffee or caffeinated beverages do you consume daily? _____
How many hours do you sleep: _____
What position do you sleep in: Back, Side, Stomach, combo of: _____
Describe your average daily diet _____

AUTHORIZATION

Our office policy maintains that payment is due at the time service is rendered. This includes your co-pay or deductible. Please be prompt in keeping appointments. If you need to re-schedule an appointment, kindly give us 24-hour notice, otherwise you are subject to a fee for the time we have reserved for you.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize and request my insurance company to pay directly to the chiropractor. I understand that my chiropractic insurance company may pay less than the actual bill of service. I agree to be responsible for payment of all services rendered on my behalf or dependents.

X _____
Signature of patient (or parent if a minor) Date

PATIENT RIGHTS TO PRIVACY RULES

As a patient of Dr. Juli Snyder you will have a right to know how your Personal Health Information may be used. You have a right to review our HIPAA Compliance Manual and to receive copies upon request. You have a right to know your Privacy Rights. You have a right to file a complaint to the office designated Compliance Officer. You have a right to get answers to your questions and concerns.

You have a right to your Personal Health Information. You have a right to obtain written documentation of how and to whom your Personal Health Information was used.

You have a right to have a copy of Notice of Privacy Practices for Patient Health Information.

I, _____, certify that I have read a copy of my rights to Privacy Rules and a copy of the Notice of Privacy Practices for Patient Health Information. I also certify that Dr. Juli Snyder has made a HIPAA Compliance Manual available to me.

Patient Name

Date

Patient Signature

Witness & Title

Date