performance
CHIROPRACTIC

Patient Information

Date _____

Name _____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

Address _____

City _____ State _____ Zip _____

Phone _____ _____
(HOME) (CELL)

Email _____

Birthdate _____ Age _____ Sex: M ☐ F ☐

Social Security # _____

Occupation _____ Employer _____

Emergency Contact _____

Name(s) _____

Relationship _____ Phone _____

Referred by _____

If not personally referred, how did you hear about our office? _____

Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐

Spouse's Name _____

Spouse's Occupation _____

Children: Yes ☐ No ☐ Age(s) _____

Insurance Information

Do you have health insurance: Yes ☐ No ☐

Party Responsible for Payment _____ Relationship to Patient _____

Insurance Company _____ Group # _____ Subscriber ID # _____

Insured's Name _____ Insured's Birthdate _____ Insured's SSN _____

Is patient covered by additional insurance? Yes ☐ No ☐

Insurance Company _____ Group # _____ Subscriber ID # _____

ASSIGNMENT AND RELEASE

I certify and understand that I am financially responsible for all charges whether or not paid by insurance. I understand that if I suspend or terminate my care/treatment, any fees for professional services will be immediately due and payable. In the event that the patient does not pay for the services rendered by Performance Chiropractic, the patient agrees to pay all attorney fees and all costs which are reasonably necessary to collect such fees. Costs include but are not limited to court costs, process service fees, computer database access, and the cost of obtaining and presenting evidence. I authorize the use of my signature on all insurance submissions. I agree to allow Performance Chiropractic to use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient Name _____ Patient Signature _____ Date _____

Guardian's Name _____ Relationship to Patient _____

Guardian's Signature Authorizing Care _____ Date _____

Reason for Visit

Check all that apply: Auto Injury* ☐ Work Injury ☐ Injury/Pain ☐ Physical ☐ Wellness Program ☐ Other ☐

Please describe _____

Date symptoms appeared or accident happened _____

Have you ever had the same condition? Yes ☐ No ☐ If yes, when? _____

Have you seen other doctors for this condition? Yes ☐ No ☐ If yes, by whom? _____

What was the outcome? _____

Have you ever been under Chiropractic Care? Yes ☐ No ☐ If yes, by whom? _____

What was the outcome? _____

Who is your Medical Doctor? _____ Phone Number _____

*If an auto accident/worker's comp, please provide: Insurance Company _____

Phone Number _____ Contact Person _____ Claim # _____

Health History

Have you been treated for any conditions in the last year? Yes ☐ No ☐ If yes, please describe _____

_____

Date of last physical _____ Have you had x-rays taken? Yes ☐ No ☐ If yes, where & when? _____

What medications or drugs are you taking and for what conditions? (Please list dosage and frequency)

_____

_____

What vitamins, minerals, or herbs do you currently take and for what conditions? (Please list dosage and frequency)

_____

_____

Please list all allergies _____

WOMEN: Are you/could you be pregnant? Yes ☐ No ☐ If yes, due date? _____ Date of last period? _____

Please check any conditions you currently have or have had in the past:

☐ AIDS/HIV
☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Anorexia
☐ Anxiety
☐ Appendicitis
☐ Atherlerosclerosis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Back pain
☐ Breast Lump
☐ Bronchitis
☐ Bulimia
☐ Breathing Problems
☐ Bruise Easily
☐ Cancer
☐ Cataracts
☐ Chest Pains/Tightness
☐ Chicken Pox
☐ Circulation Problems
☐ Cold Extremities
☐ Constipation
☐ Coughing Blood
☐ Cramps
☐ Depression
☐ Diabetes
☐ Difficulty Urinating
☐ Digestion Problems
☐ Dizziness
☐ Emphysema
☐ Epilepsy/Seizures
☐ Fainting
☐ Fatigue
☐ Fractures/Broken Bones
☐ Frequent Colds
☐ Frequent Urination
☐ Gall Bladder Problems
☐ Glaucoma
☐ Goiter
☐ Gonorrhea
☐ Gout
☐ Headaches
☐ Heart Disease
☐ Hemorrhoids
☐ Hepatitis
☐ Hernia
☐ Herniated Disk
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Hot Flashes
☐ Hypoglycemia
☐ Indigestion Problems
☐ Irregular Heart Beat
☐ Irregular Cycle
☐ Kidney Disease
☐ Kidney Infection
☐ Kidney Stones
☐ Liver Disease
☐ Loss of Memory
☐ Loss of Balance
☐ Loss of Smell
☐ Loss of Taste
☐ Low Blood Pressure
☐ Measles
☐ Migraines
☐ Miscarriage
☐ Mono
☐ Multiple Sclerosis
☐ Muscle Spasms
☐ Mumps
☐ Neck Pain/Stiffness
☐ Nervousness
☐ Nosebleeds
☐ Numbness in Fingers
☐ Numbness in Toes
☐ Osteoarthritis
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's Disease
☐ Pinched Nerve
☐ Pneumonia
☐ Polio
☐ Poor Posture
☐ Prostate Problems
☐ Prosthesis
☐ Psychiatric Care
☐ Rheumatoid Arthritis
☐ Rheumatic Fever
☐ Ringing of the Ears
☐ Scarlet Fever
☐ Sciatica
☐ Shortness of Breath
☐ Sinus Infection
☐ Sleeping Problems
☐ Spinal Curvatures
☐ Stroke
☐ Swelling of Ankles
☐ Swollen Joints
☐ Tension
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors
☐ Typhoid Fever
☐ Ulcers
☐ Unusual Bowel Patterns
☐ Vaginal Infection
☐ Varicose Veins
☐ Venereal Disease
☐ Weakness in Extremities
☐ Weight Gain/Loss
☐ Whooping Cough
☐ Other Conditions Diagnosed by a Doctor:
_____
_____
_____

Have you ever:

Broken Bones? Yes ☐ No ☐ If yes, briefly explain: _____
Been Hospitalized? Yes ☐ No ☐ If yes, briefly explain: _____
Been in an Auto Accident? Yes ☐ No ☐ If yes, briefly explain: _____
Had Sprains/Strains? Yes ☐ No ☐ If yes, briefly explain: _____
Been Struck Unconscious? Yes ☐ No ☐ If yes, briefly explain: _____
Had Surgery? Yes ☐ No ☐ If yes, briefly explain: _____

Social History

N=None L=Light M=Moderate H=Heavy

N L M H	#/day	N L M H	#/day	N L M H	#/week	N L M H
☐☐☐☐ Caffeine	___	☐☐☐☐ Sleep	___	☐☐☐☐ Exercise	___	☐☐☐☐ Water
☐☐☐☐ Salty Foods	___	☐☐☐☐ Soft Drinks	___	☐☐☐☐ Drugs	___	☐☐☐☐ Appetite
☐☐☐☐ Sugary Foods	___	☐☐☐☐ Tobacco	___	☐☐☐☐ Alcohol	___	☐☐☐☐ Stress

Family History

Have any family members currently experience or have ever experienced the following?

Arthritis Yes ☐ No ☐ If yes, briefly explain: _____
Cancer Yes ☐ No ☐ If yes, briefly explain: _____
Diabetes Yes ☐ No ☐ If yes, briefly explain: _____
Heart Disease Yes ☐ No ☐ If yes, briefly explain: _____
High Blood Pressure Yes ☐ No ☐ If yes, briefly explain: _____
Other Yes ☐ No ☐ If yes, briefly explain: _____
Are any immediate family members deceased? Yes ☐ No ☐ Age at death & cause: _____

Patient Condition

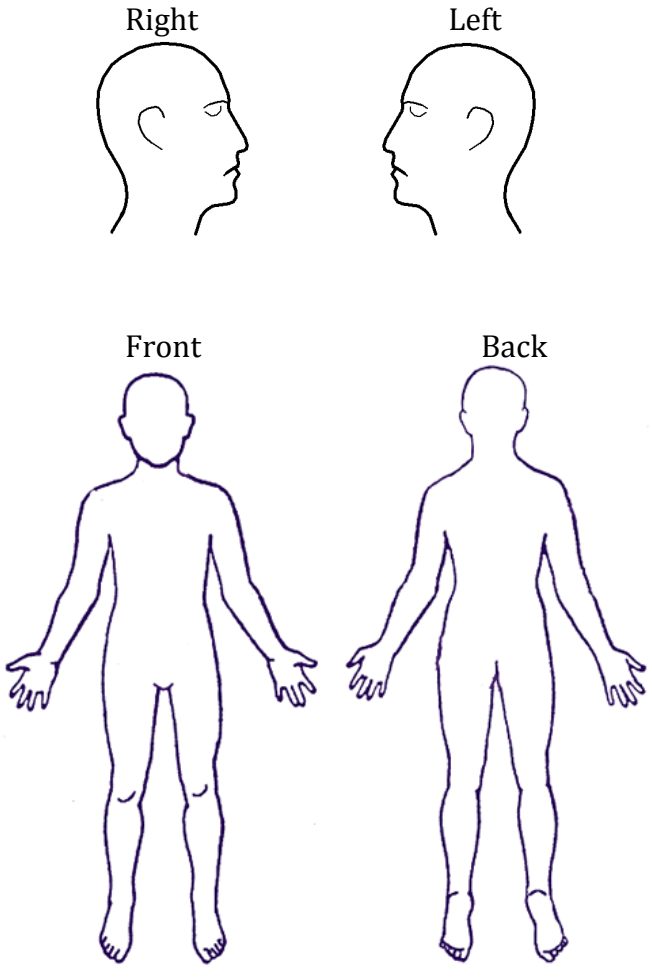
What symptoms are you experiencing? _____
_____

	Yes	No	Sometimes	
Do you experience pain every day?	☐	☐		
Is your condition getting progressively worse?	☐	☐		
Do changes in the weather affect your symptoms?	☐	☐	☐	
Does pain wake you up at night?	☐	☐	☐	How Frequent? _____
Are your symptoms worse during certain times of the day?	☐	☐	☐	What time? _____
Do your symptoms interfere with daily life?	☐	☐	☐	Describe _____

_____
What activities aggravate your symptoms? _____
_____

Rate Your Pain:

Please an "X" on the drawings below to indicate where you are experiencing pain.



What type of pain are you experiencing, please check all that apply and list pain location:

☐ Sharp _____ ☐ Dull _____
☐ Throbbing _____ ☐ Numbness _____
☐ Aching _____ ☐ Shooting _____
☐ Burning _____ ☐ Tingling _____
☐ Cramps _____ ☐ Swelling _____
☐ Stabbing _____ ☐ Soreness _____
☐ Tightness _____ ☐ Spasm _____

Please check the number that best describes your overall pain and list pain location:

☐ 0 (No Pain) _____
☐ 1 _____
☐ 2 (Mild Pain) _____
☐ 3 _____
☐ 4 _____
☐ 5 (Moderate Pain) _____
☐ 6 _____
☐ 7 _____
☐ 8 (Severe Pain) _____
☐ 9 _____
☐ 10 (Excruciating Pain) _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the doctor has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient Date

_____

Patient Signature

performance
CHIROPRACTIC

Release For Account Statements Sent Via Email

☐ I give permission for my monthly account statement to be sent via email. I understand that email is not considered secure and that my patient information will be included in the account statement.

☐ *I do not give permission for my account statements to be sent via email. Please send by regular mail to my address on file.*

_____
Email Address

_____
Patient Name

_____
Patient Signature

_____
Date