HOMETOWN
CHIROPRACTIC
1549 Ft Harrison Rd, Terre Haute, IN 47804
Phone (812)460-4700 FAX (812) 460-4701

Confidential Patient Information

Date Age DOB ((Mo/Day/Year) Sex Marital Status

First & Last Names

Street Address City State Zip Code

Mobile Phone ( ) Home Phone ( ) Work Phone ( )

Home e-mail _____Work e-mail _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

☐ **I do not want** appointment reminders via text message.

Race (check one)

☐ White ☐ Black/African American ☐ Hispanic ☐ American Indian/Alaskan Native

☐ Asian ☐ Asian Indian ☐ Chinese ☐ Other_____ ☐ I choose not to specify

Ethnicity (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐I choose not to specify

Preferred Language (check one)

☐ English ☐ Spanish ☐ American Sign Language ☐ Chinese ☐ French ☐ German

☐ Tagalog ☐ Vietnamese ☐ Italian ☐ Korean ☐ Russian ☐ Polish

☐ Arabic ☐ Portuguese ☐ Japanese ☐ Other_____ ☐ I choose not to specify

Guardian/Spouse's Full Name D.O.B.

Name, work phone and city of nearest relative (not your spouse):

Were you referred to a certain doctor in this office? Is your visit due to an accident? □ No □ Yes

Verification Question (choose only one question by circling the question, then give the answer to that question)

☐ What is the name of your favorite pet? ☐ In what city were you born? ☐ What high school did you attend?

☐ What is your favorite movie? ☐ What is your mother's maiden name? ☐ On what street did you grow up?

☐ What was the make of your first car? ☐ When is your anniversary?

Verification Answer to the above Chosen question: _____

Answers must be at least 6 characters

Family Medical History

Do you have any direct relatives (mom, dad, brother, sister, children, grandparents) been diagnosed with cancer (need specific site), diabetes (I / II), heart disease, or stroke?

Illness: _____ Illness: _____

Relation: _____ Relation: _____

Age of onset: _____ Age of onset: _____

Die from illness: ☐ Yes ☐ No Die from illness: ☐ Yes ☐ No

Illness: _____ Illness: _____

Relation: _____ Relation: _____

Age of onset: _____ Age of onset: _____

Die from illness: ☐ Yes ☐ No Die from illness: ☐ Yes ☐ No

Personal Medical History

Have you ever been diagnosed with any of the following, please check the accompanying box:

□ Cancer	□ Muscular Dystrophy	□ Rheumatic Fever	□ Digestive Disorders
□ Polio	□ Multiple Sclerosis	□ Scarlet Fever	□ Drug Abuse
□ Tuberculosis	□ Herniated disc	□ Osteoporosis	□ Stroke
□ Rheumatoid Arthritis	□ Epilepsy	□ Asthma	□ Depression
□ Heart Trouble	□ Concussion	□ High Blood Pressure	□ Venereal Disease
□ Diabetes	□ Hepatitis	□ German Measles	□ Birth Defect

Describe any operations you've had and the dates:

Have you been treated by a physician for any health condition in the last year? □ Yes □ No

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Do you currently use tobacco of any kind? ☐ Yes ☐ Former user ☐ Never

If yes, how often do you smoke: ☐ Current every day ☐ Current sometimes

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Have you had an X-ray or CT scan or MRI of your <u>low back or neck</u> spine in the past 2 years? ☐ Yes ☐ No

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Date of last physical exam and Doctor or NP's exam:

Are you now taking any medication? □ Yes □ No. What kind?

Review of Systems

<u>Constitutional</u>: Yes or NO **<u>Respiratory</u>: Yes or No** **<u>Hematology/Lymph</u>: Yes or No**

Weight Loss	☐☐	Cough	☐☐	Easy Bruising	☐☐
Fatigue	☐☐	Coughing Blood	☐☐	Gums Bleed Easily	☐☐
Fever	☐☐	Wheezing	☐☐	Enlarged Glands	☐☐
Eyes:		Chills	☐☐	**Musculoskeletal:**	
Glasses/Contacts	☐☐	**Gastrointestinal:**		Joint Pain	☐☐
Eye Pain	☐☐	Heartburn/Reflux	☐☐	Stiffness	☐☐
Double Vision	☐☐	Nausea/Vomiting	☐☐	Muscle Pain	☐☐
Cataracts	☐☐	Constipation	☐☐	Back Pain	☐☐
Ear,Nose, Throat:		Diarrhea	☐☐	**Skin:**	
Difficulty Hearing	☐☐	Jaundice	☐☐	Rashes/Sores	☐☐
Ringing in Ears	☐☐	Abdominal Pain	☐☐	Itching/Burning	☐☐
Vertigo	☐☐	Black/Bloody BM	☐☐	**Neurological:**	
Sinus Troubles	☐☐	**Genitourinary:**		Loss of Strength	☐☐
Frequent Sore Throat	☐☐	Burning	☐☐	Numbness	☐☐
Cardiovascular:		Freq Nighttime	☐☐	Headaches	☐☐
Murmur	☐☐	Blood in Urine	☐☐	Tremors	☐☐
Chest Pain	☐☐	Erectile Dys	☐☐	Memory Loss	☐☐
Palpitations	☐☐	Abn Discharge	☐☐	**Females Only:**	
Dizziness	☐☐	Bladder Leakage	☐☐	Date Last Period_____	
Fainting	☐☐	**Allergic/Immuno:**		Are you pregnant?	☐Yes ☐ No
Shortness of Breath	☐☐	Hives/Eczema	☐☐	Number of Pregnancies _____	
Difficulty Lying Flat	☐☐	Hay Fever	☐☐	**Psychiatric:**	
Swollen Ankles	☐☐	**Endocrine:**		Anxiety/Depression	☐☐
		Loss of Hair	☐☐	Mood Swings	☐☐
		Heat/Cold Intoler	☐☐	Difficulty Sleeping	☐☐

Job Description

Job title: _____ Employer_____

What activities does your job require: (ie. Lifting 50+ lbs, sitting/standing for extended periods, etc)

_____

Normal Hours worked per day: _____

Ever have a worked related injury? Please list injury and date: _____

_____

Is your visit today related to a work related injury? Yes ☐ No☐

_____

Present Complaint:

1. Describe your complaint and the area:

   _____

   How did this start? (describe activity) _____

   When did this start? _____

   Has this happened before? When? _____

   What percentage of the day is the complaint present? _____

   Please describe the pain or sensation (ie. Achey, dull, radiating, numbness etc) :

   _____

   Please circle a number that best fits your pain level:

   0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst)

   What makes this complaint worse? Such as: Activities- please list, time of day, heat, ice etc

   _____

   What makes this complaint better? Such as: postural positions, OTC, ice, heat etc

   _____

   Have you seen any other providers for this complaint? Please list name and dates, and any treatments given

   _____

   What percentage of the day is this complaint present? _____

   What activities, chores, or hobbies does this complaint affect? Please list:

   _____

2. Describe an additional complaint and the area:

   _____

   How did this start? (describe activity) _____

   When did this start? _____

   Has this happened before? When? _____

   What percentage of the day is the complaint present? _____

   Please describe the pain or sensation (ie. Achey, dull, radiating, numbness etc) :

   _____

   Please circle a number that best fits your pain level:

   0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst)

   What makes this complaint worse? Such as: Activities- please list, time of day, heat, ice etc

   _____

   What makes this complaint better? Such as: postural positions, OTC, ice, heat etc

   _____

   Have you seen any other providers for this complaint? Please list name and dates, and any treatments given

   _____

   What percentage of the day is this complaint present? _____

   What activities, chores, or hobbies does this complaint affect? Please list:

   _____

3. Describe your complaint and the area:

   _____

How did this start? (describe activity) _____

When did this start? _____

Has this happened before? When? _____

What percentage of the day is the complaint present? _____

Please describe the pain or sensation (ie. Achey, dull, radiating, numbness etc) :

_____

Please circle a number that best fits your pain level:

0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst)

What makes this complaint worse? Such as: Activities- please list, time of day, heat, ice etc

_____

What makes this complaint better? Such as: postural positions, OTC, ice, heat etc

_____

Have you seen any other providers for this complaint? Please list name and dates, and any treatments given

_____

What percentage of the day is this complaint present? _____

What activities, chores, or hobbies does this complaint affect? Please list:

_____

4. Describe an additional complaint and the area:

_____

How did this start? (describe activity) _____

When did this start? _____

Has this happened before? When? _____

What percentage of the day is the complaint present? _____

Please describe the pain or sensation (ie. Achey, dull, radiating, numbness etc) :

_____

Please circle a number that best fits your pain level:

0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst)

What makes this complaint worse? Such as: Activities- please list, time of day, heat, ice etc

_____

What makes this complaint better? Such as: postural positions, OTC, ice, heat etc

_____

Have you seen any other providers for this complaint? Please list name and dates, and any treatments given

_____

What percentage of the day is this complaint present? _____

What activities, chores, or hobbies does this complaint affect? Please list:

_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Hometown Chiropractic extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I agree, in order for Hometown Chiropractic to service my account or to collect any amounts I may owe, Hometown Chiropractic may contact me by telephone or any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Hometown Chiropractic may also contact me by sending text messages or emails, using any email address I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that Hometown Chiropractic may contact me as described above. If you fail to meet the financial obligations to this office, you agree to be responsible for collection fees of 40%, attorney's fees and court cost I hereby authorize the doctors of Hometown Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

_____

Patient's (Parent or Guardian's) Signature **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

Address:_____

I have been given a copy of Hometown Chiropractic's *Notice of Privacy Practices ("Notice*"), which describes how my health information is used and shared. I understand that Hometown Chiropractic has the right to change this *Notice* at any time. I may obtain a current copy by contacting Hometown Chiropractic's Privacy Official, or by visiting the Hometown Chiropractic web site at _www.myhometownchiropractic.com__.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name

_____

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)