Patient History Form

Date: _____/_____/_____

____

First Name Middle Name Last Name

Nick Name: ______________________ Social #:____________________________

Mailing Address:

____Apt #:________

City: __________________________________State: ____________Zip:___________

Home Phone: _____________________ Cell Phone: _________________________

Email Address:

____

Do you prefer to be reached by: Email Telephone

Date of Birth: ______/______/______Age: _____________________ Sex: M F

Are you: Minor Single Married Divorced Widowed

Spouse Name: ____

Number of Children: ______Children's Names:_________________________________

Employment Status: Full time Part time Retired Unemployed Student Other

Your Employer:____

Work Phone: _________________________Occupation: ______________________

If you are a College Student are you?: Full time Part time

Financially Responsible Party: Self Spouse Parent Other

Emergency Contact: (Name, Phone #) ____________________________________

Responsible Party

Name of Person Responsible for this account:_________________________________

Relationship to Patient: ____________________Phone #_______________________

Address: __________________________________City: ____________Zip: ______

Name of employer: ______________________ Work # ________________________

REFERRAL SOURCE

Were you referred by a patient of ours? Yes No

Patient's Name: ____

Were you referred by the internet? Yes No

If so, any particular directory or site? ____________________________________

Were you referred by: Doctor Referral Lecture / Screening MAC Other:

If so by who? ____

General Insurance Information

We will help you in any way we can for you to file your Insurance claim, however we <u>do not</u> accept insurance reimbursements for Sports Chiropractic Services. In the past, we have seen patients get back an average of 60-80% from there insurance carriers, If they have a PPO plan, and after the deductible is meet. For more info on why we do not take insurance please refer to our website.

Name on the Insurance: ____

Insurance Company: ___________________________________Group #___________

Insurance Phone #:__________________________________ PPO / HMO / Other___

How much is your Out of Network Deductible? _____How much have you used? _____

Maximal Annual Out of Network Benefits:____________________________________

Symptoms

Reason for the visit: ______________________________

When did you first notice the Symptoms? ______________________________

Is this condition getting progressively worse? ______________________________

Where specifically is the problem(s) located? ______________________________

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

Rate the severity of your pain (0 none..5 moderat..10 severe pain) 0 1 2 3 4 5 6 7 8 9 10

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

What treatment have you already received for you condition? ______________________________

Health History

(Check only those conditions which are applicable)

AIDS/HIV	Cataracts	Hepatitis	Osteoporosis	Suicide Attemps
Alcoholism	Chemical D/O	Hernia	Pacemaker	Thyroid Problem
Allergy Shots	Chicken Pox	Herniated Disc	Parkinson's	Tonsillitis
Anemia	Depression	Herpes	Pinched Nerve	Tuberculosis
Anorexia	Diabetes	(H) Cholesterol	Pneumonia	Tumors, Growths
Appendicitis	Emphysema	Kidney Disease	Polio	Typhoid Fever
Arthritis	Epilepsy	Liver Disease	Prostate Problem	Ulcers
Asthma	Fractures	Measles	Prosthesis	Venereal Disease
Bleeding D/O	Glaucoma	Migraine H/A	Psychiatric Care	Whooping Cough
Brest Lump	Goiter	Miscarriage	Rheumatoid Arth.	Other: _________
Bronchitis	Gonorrhea	Mono	Rheumatic Fever	_________________
Bulimia	Gout	M. S.	Scarlet Fever	_________________
Cancer	Heart Disease	Mumps	Stroke	_________________

Dates of Last Exams: ______________________________

Pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

List any types of surgeries which you have had and the dates which they occurred:

____

____

Please list all Medications you are currently taking: ______________________________

____

Allergies: ______________________________

Daily Habits

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

What do your daily work habits include? (sitting, standing, light labor, Computer work)

____

What vitamins do you currently take? ______________________________

What kind of other nutritional supplements do you take? ______________________________

Do you smoke? Yes No How much per day? ______________________________

How much liquor do you consume on a weekly basis? ______________________________

How much coffee or caffeinated beverages do you consume on a daily basis? ________

Sports History

Were you active in sport(s)? Yes No
Which one(s)? ______________________________
Are you currently active in sports? Yes No
Which one(s)? ______________________________
Have you been hurt in any of these Sports? Yes No
When/ How? ______________________________

Chiropractic History

Have you ever received any form of Chiropractic Care? Yes No
If yes, who was your Chiropractor Practitioner? ____________________State: _____
If yes, for how long did you receive care? ______________________________
If yes, how often did you go? ______________________________
If yes, when was your last visit? ______________________________
If you stopped, why did you stop? ______________________________
Does anyone in your immediate family receive chiropractic care? Yes No

Diagnostic History

***** If possible bring your old diagnostic images and report with you when you come in for your apt*****

Has anyone ever taken imaging of your injured area? Yes No When? __________
Who has the images now? ______________________________
What is that office's phone #______________________________

Have you had, or do you receive any of the following:

(Include……. When, How Often, Last Session)

Exercise Training: Yes No Massage: Yes No
____
Yoga: Yes No Acupuncture: Yes No
____
Other Modalities: Yes No
____

Would you like to subscribe to our Email Newsletter? Yes No

For your Convenience we will send Email Appointment Reminders.

Authorization Consent

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 understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during or after the period of chiropractic care, to any third party payers and/or health practitioners. I agree to be responsible for payment of all services rendered at the time of treatment on my behalf or my dependents behalf. I give permission to Dr. Bart Kennedy, D.C., C.C.S.P. to administer chiropractic treatment at Rock Sports and Spine therapy as explained to me, including the benefits and risks involved with the application of chiropractic manipulative therapy and the physical modalities used at this office. I also, agree that the Practice's Privacy Notice has been provided to me prior to my signing this Consent and that I read and fully understand it.

Sign X______________________________Date ______________