



INSTRUCTIONS:

To make your appointment go as quickly and smoothly as possible please:

- 1 Print these pages (this instruction page and the four pages that follow).
- 2 Fill out the Confidential Patient Information Form and sign.
- 3 Fill out the General Health History Forms with any and all past history.
- 4 If the appointment is for a minor, please read the *Consent to Treat Section* carefully and sign.
- 5 Please call with any questions you may have regarding completion of this packet. This will help to speed up your appointment.

Thank you for choosing Committed to Health Chiropractic Center for your health needs.

Committed to Health Chiropractic Center

CONFIDENTIAL PATIENT INFORMATION FORM

Date: _____

[] M [] F

Name: _____ Email: _____

Street Address: _____ Home Phone: _____

City/State/Zip: _____ Date of Birth: ____/____/____ Age: _____

Work Phone: _____ Employer: _____ Occupation: _____

Social Security #: _____ - _____ - _____ [] Single [] Married [] Widowed [] Separated [] Divorced

Spouse Name: _____ Spouse Employer: _____

Emergency Contact (if other than spouse): _____ Daytime Phone: _____

Name of Parent/ Guardian (if under 18): _____ Work Phone: _____

Whom may we thank for referring you to us? _____

IS THIS VISIT RELATED TO A:

- | | | |
|--|---|--|
| <input type="checkbox"/> Work Related Injury | <input type="checkbox"/> Motorcycle-Bicycle Injury | <input type="checkbox"/> Home Injury |
| <input type="checkbox"/> Sports or Recreational Injury | <input type="checkbox"/> Non-Injury Symptoms | <input type="checkbox"/> Check-up Only |
| <input type="checkbox"/> Car Crash Injury | <input type="checkbox"/> School/Employment Physical | <input type="checkbox"/> Other (Describe): |

INSURANCE INFORMATION

Does your insurance cover Chiropractic treatment?	<input type="checkbox"/> Yes, <input type="checkbox"/> No If yes, we need a copy of the card
If yes, indicate Insurance Company Name.	Carrier Name: _____
If you are being seen for a work related or car accident injury we need the Claim Number and the Claims Adjusters Name. If unknown, be certain to let the front desk staff know.	Address: _____
	Telephone: _____
	Claim Number: _____
	Claim Adjusters Name: _____
Are you the:	<input type="checkbox"/> Insured, <input type="checkbox"/> Dependent of the insured (spouse or child)
If you are the insured persons dependent (spouse or child), we need the insured persons name, date of birth, social security number in order to do the billing.	Name of Insured: _____
	Social Security #: _____
	Date of Birth: _____
What is your co-payment amount for each visit?	\$ _____
What percentage does your insurance pay?	Percentage (%): _____
What is your insurance deductible amount each year?	\$ _____
Have you met your deductible this year?	<input type="checkbox"/> Yes, <input type="checkbox"/> No
Does your insurance policy limit each office payment amount?	<input type="checkbox"/> Yes, <input type="checkbox"/> No Limit is: \$ _____
Does your insurance limit the number of office visits per year?	<input type="checkbox"/> Yes, <input type="checkbox"/> No Number: _____
Does your insurance limit the amount paid per year?	<input type="checkbox"/> Yes, <input type="checkbox"/> No Limit is: \$ _____

Our office will provide insurance billing services for you if you so desire as a courtesy. *Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office.*

IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT FOR REGULAR INSURANCE PATIENTS.

Signature of responsible party (Patient or Parent): _____ Date: _____

Patient Name: _____

GENERAL HEALTH HISTORY

Patient Condition:

Describe the major complaints that brought you to our office: Headaches/Migraines Neck pain/stiffness

Upper back pain/stiffness Mid-back pain/stiffness Low back pain/stiffness

Shoulder / Elbow / Wrist / Hand pain Numbness/tingling down: Arm / Leg

Hip / Knee / Ankle / Foot pain/stiffness Other: _____

Approx. when did your complaint begin? Gradually / Suddenly ____/____/____ Time ____:____ AM PM

What caused it? _____

My pain is: Forgotten with Activity Noticeable but Able to Continue Activity Prevents Certain Activities

Activities that are difficult/ painful to perform: Sitting Standing Walking Lying Down

Bending Turning Twisting

Does it affect your: Work Sleep Recreation Daily Routine

Has there been any change in the following since the onset of your complaint: No Change to Any of These

Balance Coordination Grip Weakness Breathing Low grade fever

Hearing Vision Digestion Weight Menstrual Coughing

Sneezing Urination Bowel Habits Sexual

Past Medical History:

Has this condition occurred before? Yes No If yes, describe: _____

Have you seen another doctor for this condition? Yes No Who? _____

Treatment Received Medication Surgery Physical Therapy Chiropractic Other: _____

Have you ever been to a Chiropractor before for any other condition? Yes No Who? _____

Current Family Physician: Dr. _____ Phone: _____ Date of last visit? _____

May we communicate with your family doctor about your diagnosis / treatment / progress in our office? Yes No

When is your pain usually better?

Morning Afternoon Evening

During Sleep Hours Lying Down Flat Standing

Walking Sitting Rest

Stress (mental) is less Good Posture Exercise/Stretching

Prior Injury or Musculoskeletal Pain History: I have no history of previous painful injury or pain.

If you have had prior injuries or pain, please check below:

Work Injury Fall Sports Injury Lifting Injury Car accident

Motorcycle Injury Bicycle Injury Pedestrian Injury Other Injury Headaches/Migraines

Neck/Arm Pain Middle Back Pain Low Back/Leg Pain Other Pain _____

Review of Systems: (Please circle any condition you are currently experiencing.)

Constitutional: Fever Weight Loss Weight Gain Chills Other _____

Neurologic: Headache Dizziness Memory Loss Numbness Other _____

Eyes: Glasses Contacts Double Vision Blurriness Other _____

Ears/Throat: Deafness Ringing Ears Hoarseness Swallowing Other _____

Cardiac: Chest Pain Skip Beats Rapid Beat Edema/Ankle Swelling Other _____

Pulmonary: Cough Cough Blood Short of Breath Wheezing Other _____

Intestinal: Diarrhea Bleeding Incontinence Constipation Other _____

Urinary: Burning Bleeding Incontinence Increased Frequency Other _____

Musculoskeletal: Pain Weakness Arthritis Joint Swelling Cane/walker

Skin: Bruising Lesions Birth Marks Other _____

Hematologic: Bleeding Transfusions Hepatitis Other _____

Psychiatric: Depression Insomnia Fatigued Nervousness Other _____

Miscellaneous: Metal Implants Claustrophobic Other _____

Patient Name: _____

GENERAL HEALTH HISTORY-Page 2

Medical History: Do you have or have you had any of the following?

- | | | | |
|---|--|--|--|
| Yes No | Yes No | Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack | <input type="checkbox"/> <input type="checkbox"/> Heart Failure | <input type="checkbox"/> <input type="checkbox"/> Heart Valve | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Abnormal Rhythm |
| <input type="checkbox"/> <input type="checkbox"/> COPD (Lungs) | <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Aneurysm | <input type="checkbox"/> <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> <input type="checkbox"/> Reflux Disease | <input type="checkbox"/> <input type="checkbox"/> Liver Trouble | <input type="checkbox"/> <input type="checkbox"/> Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> <input type="checkbox"/> Blood Clots | <input type="checkbox"/> <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> <input type="checkbox"/> Gout | <input type="checkbox"/> <input type="checkbox"/> Depression | <input type="checkbox"/> <input type="checkbox"/> Bipolar |
| <input type="checkbox"/> <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> <input type="checkbox"/> Neuropathy | <input type="checkbox"/> <input type="checkbox"/> Alcoholism | <input type="checkbox"/> <input type="checkbox"/> HIV/Aids |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> <input type="checkbox"/> Serious Injury | <input type="checkbox"/> <input type="checkbox"/> Are you pregnant? |

Please give details to those answered yes: _____

Previous Surgeries: If you have had any previous surgery, indicate type and when:

I have never had any surgical procedures.

Surgery	Year	Surgery	Year
<input type="checkbox"/> Spine Surgery (neck or back)	_____	<input type="checkbox"/> Appendix	_____
<input type="checkbox"/> Disc Surgery (neck or back)	_____	<input type="checkbox"/> Gallbladder/Stomach/Kidney	_____
<input type="checkbox"/> Heart	_____	<input type="checkbox"/> Cancer (any type)	_____
<input type="checkbox"/> Tonsillectomy	_____	<input type="checkbox"/> Rib/Collar Bone	_____
<input type="checkbox"/> Head/Brain	_____	<input type="checkbox"/> Hernia	_____
<input type="checkbox"/> Shoulder/Arm/Leg	_____	<input type="checkbox"/> Other _____	_____

Are you taking any medications/ supplements? (Check any of the following that you are taking currently.)

I am not taking any medications/ supplements currently.

- Muscle Relaxants Aspirin Anacin Anti-inflammatory Tylenol Bufferin Narcotics for Pain
 Advil/Motrin Stroke Prevention Meds Heart Medications Birth Control Medications Other _____

Allergies: **I have no known allergies.**

I have the following allergies: _____

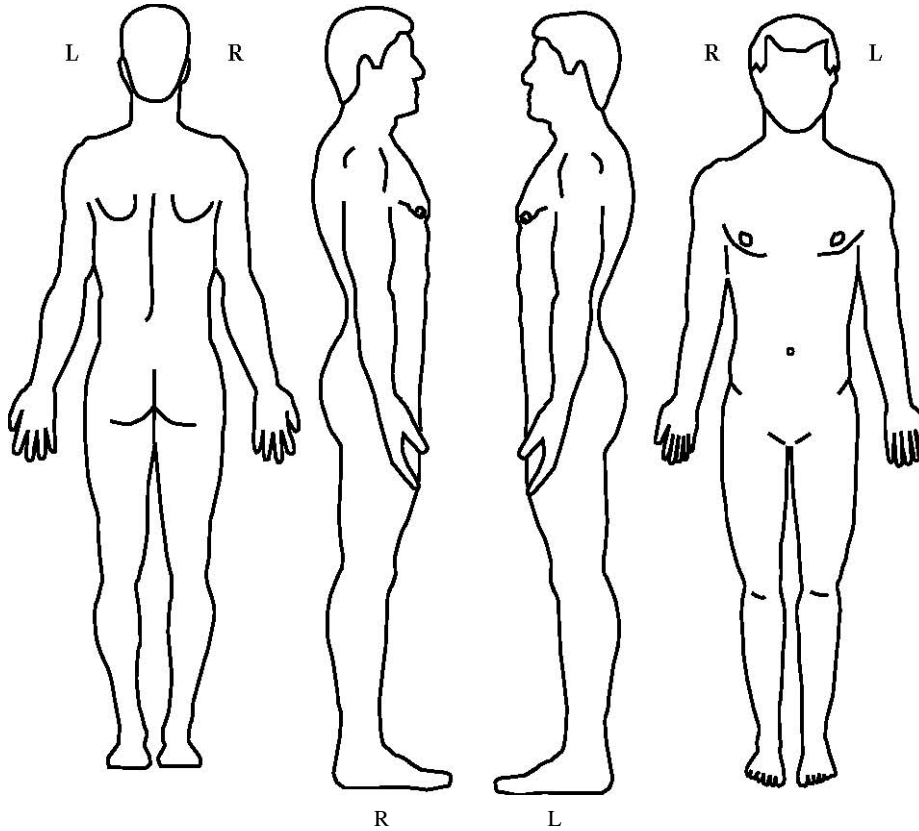
Family History: Please check any problems that run in your family.

- | | | | |
|--|---|--|---|
| Yes No | Yes No | Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack | <input type="checkbox"/> <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Aneurysm | <input type="checkbox"/> <input type="checkbox"/> Gout | <input type="checkbox"/> <input type="checkbox"/> Kidney Trouble/Stones |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Alcoholism | <input type="checkbox"/> <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> <input type="checkbox"/> Cancer—if yes what type? _____ | | | |

Other: _____

Patient Name: _____

PAIN DRAWING



Mark as follows: A- Ache B- Burning N- Numbness P- Pins & Needles S- Stabbing O- Other-_____ Describe _____

Consent: I (or if I am the parent/ legal guardian of the patient seeking care) do hereby request and authorize Dr. Paul Hyland, Committed to Health Chiropractic Center, LLC, associates and/or assistants to perform examination and diagnostic procedures arising from the above described condition. I understand that they have the right to refuse to accept me (or said minor) as a patient at any time before treatment begins. The taking of a history, the conducting of a physical examination, and the performance of any diagnostic procedures, are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient. Should examination reveal any special deficiency and I am accepted as a patient, I authorize Committed to Health Chiropractic Center, LLC, Dr. Paul Hyland, associates and/or assistants to administer any treatment that is necessary.

Print Name (Patient/ Parent/ Guardian) _____

Signature of Patient/ Parent / Guardian _____ Date: _____