



ID#: _____

Perry Chiropractic Health Center

Patient Information:

Name: _____ Today's Date: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email Address: _____ Marital Status: Single Married

Social Security #: _____ Birth Date: ____/____/____ Age: _____

Gender: Male Female Unspecified Race: _____ Ethnicity: _____

Employer: _____ Occupation: _____

Number of children and ages: _____

Emergency contact name: _____ Relationship: _____ Phone #: _____

Have you ever seen a chiropractor before? Yes No If **yes**, for what? _____

Whom may we thank for referring you to our office? _____

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Perry Chiropractic Health Center, or Dr. Brian Gillis, D.C for services rendered. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care (if a minor): _____ Date: _____

History of Complaint:

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

When did the problem(s) begin? _____ When is the problem at its worst? AM PM Mid-day

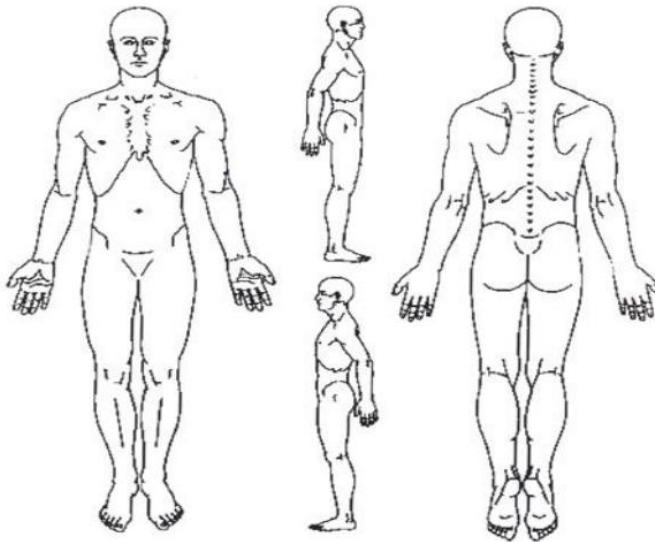
How long does it last? Constant **OR** On and off during the day **OR** Comes and goes throughout the week

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? Yes No **If yes**, when? _____ By whom? _____

PLEASE MARK the areas on the body diagram with the following letters to describe your symptoms:

R = Radiating **B = Burning** **D = Dull** **A = Aching** **N = Numbness** **S = Sharp/Stabbing** **T = Tingling**



Past Medical History:

Have you suffered with any of this problem or similar in the past? Yes No **If yes**, how many times? _____

When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: Yes No **If yes**, what type of treatment? _____

Who provided it? _____ How long ago? _____ Results Favorable Unfavorable

List any medications you are taking: _____

Are you allergic to any medications? Yes No **If yes**, please list: _____

List any surgeries you have had over the course of your life:

Family / Social History:

Does anyone in your family suffer with the same condition(s)? Yes No If yes, whom?

Grandmother Grandfather Mother Father Sister(s) Brother(s) Son(s) Daughter(s)

Any other hereditary conditions the doctor should be aware of? No Yes _____

Smoking: Cigars Pipe Cigarettes How often? Daily Weekends Occasionally Never

Alcohol: Consumption occurs Daily Weekends Occasionally Never

Recreational Drug Use: Daily Weekends Occasionally Never

Review of Systems:

Please check all symptoms you have ever had, even if they do not seem related to your current problems:

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Numb/Tingling | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Jaw/TMJ Pain | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bladder Problem |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Infertility | <input type="checkbox"/> Elbow/Wrist Pain | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Seizures | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Foot Pain |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Skin problems | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Disc Problems | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Hip/Leg Pain |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Constipation | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Sciatic Pain | <input type="checkbox"/> Diabetes (1 or 2) |

Informed Consent:

I have been advised that chiropractic care, like all other forms of health care, holds certain risks. These risks include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, strains and dislocations, and costovertebral strains and separation. Rare complications include but are not limited to stroke which occurs at a rate between one instance per one million to one per two million, have also been associated with chiropractic care.

Treatment objectives, as well as the risks associated with chiropractic adjustments and other procedures provided at Perry Chiropractic Health Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I consent to treatment that the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Patient Name (print)

Patient or authorized signature

Date

Health Care Authorization Form

Patient's Name _____ Date of Birth: _____

The patient identified above authorizes **Perry Chiropractic Health Center** to use and/or disclose protected health information in accordance with the following:

- I give permission to **PCHC** to use my address, phone number, and clinical records to contact me by phone, text, or email with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, thank you cards, testimonials, marketing materials, information about treatment alternative, or other health related information.
- If **PCHC** contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.
- I give **PCHC** permission to text me with appointment reminders and/or missed appointment details.
- I give **PCHC** permission to treat me in an open therapy room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

Financial Authorization

- I understand that estimated insurance coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility of their account balance. The estimation is based on a negotiated contract and any remaining balance due will be billed to you after additional information is received from your insurance company.

I understand that I am responsible for payment on the day that services are rendered.

By signing this form, you are giving **PCHC** permission to use and disclose your protected health information in accordance with the directives listed above.

Patient signature: _____ Date: _____

Female patients only: To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the X-rays are taken at **PCHC**. Date of last menstrual cycle: ____/____/____

Signature: _____ Date: _____