Walk-In Chiropractic
Confidential Health History

Name:_____ **Home Phone:**_____

Address:_____ **Cell Phone:**_____

City:_____ **State:**_____ **Date of Birth:**_____

Zip Code:_____ **Sex:** M or F or other

Marital Status: M S W D

Employer:_____ **Work Location:**_____

Occupation:_____ **Work Phone:**_____

_____

Please describe your health problem: _____

_____

_____

List any other doctors seen for this problem:

_____

_____

List any diagnosis and/or treatments: _____

_____

_____

List any unusual diseases and year or occurrence/diagnosis:

_____

_____

Have you been treated for any health condition in the past year?

_____

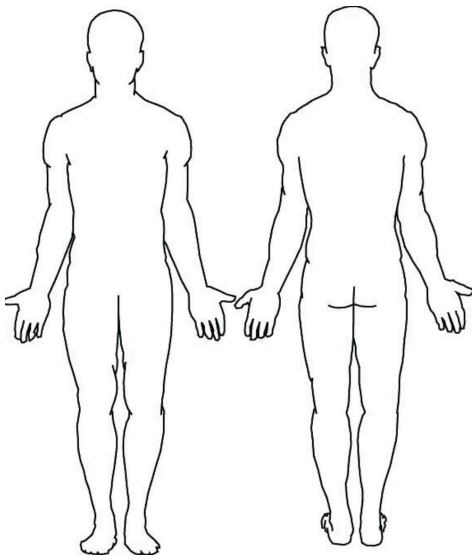
_____

Have you received chiropractic treatment previously? If yes, explain:

_____

_____

_____



Please mark your areas of pain on the figures to the left.

Rate and describe your pain for each area on a scale from 0-10, 0 being none and 10 being the worst.

_____ **sharp/stabbing dull/ache tingling numbness**

_____ **sharp/stabbing dull/ache tingling numbness**

_____ **sharp/stabbing dull/ache tingling numbness**

Please circle the condition(s) you are now having and those you frequently have.

Musculo-Skeletal	Nervous System	Cardiovascular System
Low Back Problems	Numbness	Chest Pain
Pain between Shoulders	Loss of Feeling	Pain over heart
Neck Problems	Paralysis	Difficulty Breathing
Arm Pain	Dizziness	Persistent Cough
Leg Problems	Fainting	Coughing Phlegm
Swollen Joints	Headaches	Coughing Blood
Painful Joints	Muscle Spasm	Rapid Heartbeat
Stiff Joints	Convulsions	Blood Pressure Problems
Sore Muscles	Forgetfulness	Heart Problems
Weak Muscles	Confusion	Lung Problems
Walking Problems	Depression	Varicose Veins
Broken Bones		

Please circle the condition(s) you are now having and those you frequently have.

Gastro-Intestinal	Genito-Urinary System	Eye. Ear, Nose and Throat
Poor Appetite	Bladder Trouble	Eye Strain
Excessive Hunger	Excessive Urine	Eye Inflammation
Difficulty Chewing	Scanty Urination	Vision Problems
Difficulty Swallowing	Painful Urination	Hearing Loss
Excessive Thirst	Diarrhea	Ear Discharge
Nausea	Constipation	Nose Pain
Vomiting Food	Black Stool	Nose Bleeding
Vomiting Blood	Bloody Stool	Nose Discharge
Abdominal Pain	Hemorrhoids	Difficulty breathing through Nose
Liver Trouble		Dental Problems
Gallbladder Problems		Sore Mouth
Weight Trouble		Sore Throat
		Difficulty with Speech
		Ear Pain
		Tinnitus (ringing in ears)

·–

Family History	Diseases in the Family? (Arthritis, Heart Disease, Cancer, Diabetes, Multiple Sclerosis?)	Living or deceased?
Mother		
Father		
Brothers		
Sisters		
Grandmother(s)		
Grandfather(s)		

Please list ALL surgeries	Year of Surgery

Please any allergies to food, medication and other factors

Please list any supplements and dosages	

Do you exercise regularly? Please list what type and how often.	

Smoking Status:
Please check one:

____ Never a smoker

____ Current everyday smoker_____packs per day

____ Current periodic smoker. How often_____

____ Former Smoker. Quit in_____year.

How many Children do you have? _____

Do you drink alcohol?_____drinks per day/month (please circle)

Caffeine? How often?_____How much? _____
What kind of caffeine (circle)? Coffee Soda Tea

Current Medications	**Dosage**

Signature _____

Date_____

HIPAA Acknowledgement of Receipt of Notice of Walk-in Chiropractic's Privacy Practices

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq. and regulations there under, as amended from time to time (collectively referred to as "HIPAA"). This authorization affects your rights in the privacy of your personal healthcare information.

By signing this authorization, you acknowledge and agree that Walk-in Chiropractic's ("Practice") or its Business Associates may use or disclose your Protected Health Information (PHI) for the purpose of providing treatment, for purposes of relating to the payment of services rendered, and for the Practice's healthcare operations purposes.

Further, by signing this authorization, you acknowledge that you have been provided a copy of and have read and understand Walk-in Chiropractic's Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Walk-in Chiropractic has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available and can be received by sending a written request with return address to the center where you were seen.

By signing below, you are acknowledging that you have received, reviewed, understood and agreed to the Notice of Privacy Practices of Walk-in Chiropractic's, which describes the Practice's policies and procedures regarding the use and disclosure of any of your Personal Health Information created, received, or maintained by the Practice.

Acknowledged and agreed to by:

Patient

By:_____Date: _____

Print Name _____

OR, ON BEHALF OF PATIENT

By:_____Date: _____

Print Name _____

EMERGENCY CONTACT INFORMATION

Information about you, your appointment time or your examination results cannot be disclosed to persons other than you, unless you authorize us to do so. If you wish to disclose information to persons other than you, please indicate who they are below.

NAME	Relationship	Telephone Number

Signature:_____

Date:_____