SOUTH COUNTY CHIROPRACTIC
ACUPUNCTURE ▪ FAMILY CARE ▪ SPORTS REHAB

Patient Information

Personal Information

First Name:_____
Middle Name: _____
Last Name: _____
Preferred Name: _____
Date of Birth: _____
Social Security #: _____
Marital Status: □S □M □D □W
Gender: □Male □Female
Race:_____
Ethnicity: □Hispanic or Latino □ Not Hispanic/Latino
□Decline to Specify

Contact Information

Address: _____
_____
_____
Cell Phone: _____
Home Phone: _____
Work Phone: _____
Email address:_____
(we will NOT share your email with any third party)
Appointment Reminders: □Text □Email □Both
□I do not want appointment reminders
Emergency Contact: _____
Phone: _____

Employment Information

Work Status: □Employed □Retired □Student □Unemployed □Other
Employer Name: _____
Employer Address:_____
_____
Employer Phone: _____
Occupation:_____
Physical Work Duties: _____
Hours per week: _____

Insurance and Payment for Care

How do you plan to pay for care? □Personal Insurance □No Insurance, Self Pay □Third-Party Insurance

Primary Insurance

Insurance Company: _____
ID/Policy #:_____
Group #: _____
Insured's Name:_____
Insured's Date of Birth: _____
Relationship to Insured:_____

Secondary Insurance

Insurance Company:_____
ID/Policy #: _____
Group #: _____
Insured's Name: _____
Insured's Date of Birth:_____
Relationship to Insured: _____

I authorize the release of any medical or other information necessary to process my insurance claims to the insurance provider(s) listed above.
I authorize payment of medical benefits to my physician for services rendered in the office.
Benefits are subject to all contract limits and the member's status at the time of visit. It is up to the member to be aware of their coverage. Any quotes given at the time of service are subject to change based on the insurance company's determination of benefits after claims are submitted.

Accident or Injury Information

Symptoms are a result of: □Work Injury □Automobile Accident □Another Type of Accident □None of these
Date of your Accident:_____
State in which Accident Occurred:_____

Referral

Who may we thank for referring you to the office or how did you hear about our office?

_____

Signature _____ **Date**_____

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Personal Health History

Primary Care Physician: _____

Physician Phone: _____

Date of Last Physical: _____

Please list any health conditions for which you have been treated in the last year:

_____

_____

_____

_____

_____

_____

_____

Have you had prior chiropractic care? □Yes □No

Date of last chiropractic visit: _____

Smoking Status: □Current □Occasional □Past □Never

Start Date: _____ End Date: _____

Are you currently pregnant or planning? □Yes □No

Please list your current medications below:

_____

_____

_____

_____

_____

_____

Please list any medication allergies below:

_____

_____

_____

Personal Incident History

Broken Bones	□Yes □No	If you answered yes, please explain below:
Hospitalizations	□Yes □No	_____
Surgeries	□Yes □No	_____
Major Sprains/Strains	□Yes □No	_____
Pacemaker/Defibrillator	□Yes □No	_____
Stroke	□Yes □No	_____
Auto Accidents	□Yes □No	_____

Family Health History

Please list diagnosed health conditions and untimely deaths. Family members include parents, siblings, maternal and paternal grandparents/aunts/uncles. Please list both condition and the relation to you.

_____

_____

_____

_____

_____

_____

_____

_____

Social History

Exercise □Daily □2-3x/week □Weekly □Monthly □None

Alcohol □Daily □2-3x/week □Weekly □Monthly □None

Drugs □Daily □2-3x/week □Weekly □Monthly □None

Water/day □8+cups □4-6 cups □2-4 cups □less than 2 cups

Signature _____ **Date** _____

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Current Complaint

What is your **main** area of complaint today?

_____

How long has your pain been present?

_____

How did your pain begin?

_____

Please describe your pain below:

_____

_____

Select the frequency at which you experience your pain:

□Always □Hourly □Daily □Weekly □Occasionally

What daily activities does this pain interfere with?

_____

On the scale below, mark where you rate your pain today:

No pain	1	2	3	4	5	6	7	8	9	10

List anything that makes your condition better:

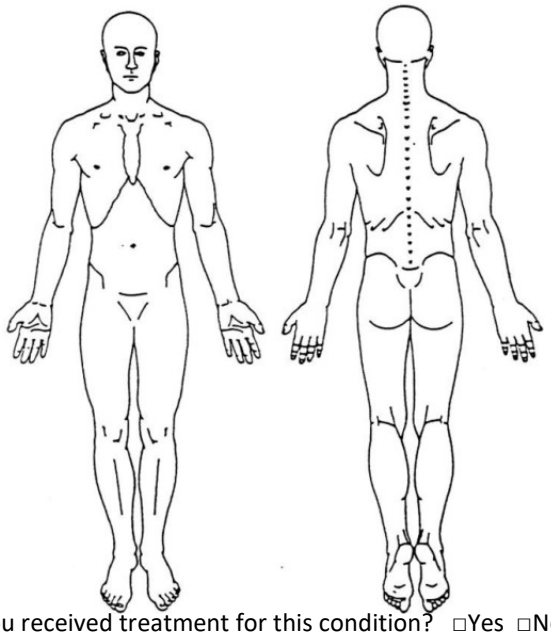
_____

List anything that aggravates your condition:

_____

Place an **X** over your area(s) of complaint

Place an **O** over any radiation of pain



Have you received treatment for this condition? □Yes □No

If so, explain: _____

Have you had x-rays taken for this condition? □Yes □No

When and where: _____

Other Areas of Complaint

Do you have any additional areas of complaint today? □Yes □No

If so, please describe this pain below including location, duration, severity and description of your symptoms.

_____

_____

_____

Goals of Care

What are your 3 main goals to achieve with care?

1._____

2._____

3._____

Signature _____ **Date** _____

Office Use Only

Height: _____ft _____in Weight: _____lbs Pulse: _____bpm SpO2: _____% Blood Pressure: _____/_____mmhg

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Notice of Privacy Practices – Acknowledgement & Consent

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by South County Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Signature _____ **Date** _____

Printed Name _____ **Relation to Patient** _____

Witness Signature _____ **Date** _____

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Consent to Examination and Treatment

The Examination: Prior to receiving care, a health history and an examination will be completed to assess your specific condition and overall health. These procedures will help in determining if care is applicable at this time, or if any further examinations or studies are needed.

The material risks inherent to your treatment: Chiropractic and acupuncture are safe and effective approaches for many health conditions, however as with any health care procedures, treatments present the risks of complications or negative side effects.

- **Chiropractic Manipulation Therapy** Negative effects of a chiropractic adjustment are exceedingly rare but could include, but are not limited to sprains, dislocations, disc injuries, fractures and strokes. A more common side effect associated with the adjustment is mild soreness or stiffness following your treatment.
- **Supportive Therapies** Electrotherapy, kinesiology taping, ultrasound and others are used in the office. Please let your doctor know if you have any metal implants, a pacemaker or defibrillator, are pregnant, or have sensitive skin.
- **Acupuncture Needling** Minor Bleeding after removal of the needles is the most common side effect of acupuncture. Please inform the doctor if you are taking a blood thinner, have a clotting disorder, or bruise easily. Some patients have a conscious or unconscious fear of needles which can produce dizziness and other symptoms of anxiety. If you experience dizziness, the acupuncturist will remove the needles and ask you to lie down to reduce the likelihood of fainting.

Financial Policy

Please note, not all insurance plans cover chiropractic and acupuncture services. We are in network with most major insurance companies including Medicare. We will do our best to verify coverage at or prior to your first appointment. If your plan includes coverage and we are in network, we will submit proper forms for you to utilize your benefits. We ask that you pay your anticipated co-payment at the time of your visit, and that you understand that any additional fees not covered by your insurance will be billed to you. Any questions you may have about your insurance coverage or cost of care can be addressed by our front desk staff and/or your doctor.

Authorization

I certify that I am the patient or legal guardian. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the information provided to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctor(s) see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me and I'm responsible for timely payment. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon my suspension or termination of care unless other arrangements are made in writing. It is not reasonable to expect my doctor to be able to anticipate or explain all possible risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise professional judgement during the course of any procedures which he or she feels at the time to be in my best interest.

Signature _____ **Date** _____

Printed Name _____ **Relation to Patient** _____