Committed to Health
Chiropractic Center

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: _____ Date of Birth: ____/____/_____ Age: _____

Street: _____City/State/Zip:_____

Home#: _____ Cell#: _____ Social Security #: _____-_____-_____

Email: _____ ☐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: _____

Employer: _____ Occupation: _____ Work#: _____

Whom may we thank for referring you to us? _____

Information provided is confidential and cannot be released or sold to a third party without prior consent

Preferred Contact for Appointment Alerts: ☐Text Msg ☐Email ☐Call Cell ☐Call Home ☐Call Work

Preferred Contact for Special Events/Discounts: ☐Text Msg ☐Email

IS THIS VISIT RELATED TO A:

☐ Work Related Injury	☐ Motorcycle-Bicycle Injury	☐ Home Injury
☐ Sports or Recreational Injury	☐ Non-Injury Symptoms	☐ Check-up Only
☐ Car Crash Injury	☐ School/Employment Physical	☐ Other (Describe):

INSURANCE INFORMATION

Does your insurance cover Chiropractic treatment?	☐Yes, ☐No If yes, we need a copy of the card
If yes, indicate Insurance Company Name. **If you are being seen for a work related or car accident**	Carrier Name: _____ Address: _____ Telephone: _____
injury we need the Claim Number and the Claims Adjusters Name. If unknown, be certain to let the front desk staff know.	Claim Number: _____ Claim Adjusters Name: _____
Are you the:	☐Insured, ☐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?	$

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

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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

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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	
☐	☐	Heart Attack	☐	☐	Heart Failure	☐	☐	Heart Valve	☐	☐	High Blood Pressure
☐	☐	Heart Murmur	☐	☐	Asthma	☐	☐	Pacemaker	☐	☐	Abnormal Rhythm
☐	☐	COPD (Lungs)	☐	☐	Emphysema	☐	☐	Tuberculosis	☐	☐	Diabetes
☐	☐	Thyroid Trouble	☐	☐	Stroke	☐	☐	Aneurysm	☐	☐	Ulcers
☐	☐	Reflux Disease	☐	☐	Liver Trouble	☐	☐	Hepatitis	☐	☐	Kidney Trouble
☐	☐	Kidney Stones	☐	☐	Urinary Problems	☐	☐	Anemia	☐	☐	Bleeding Disorder
☐	☐	Blood Transfusion	☐	☐	Blood Clots	☐	☐	Osteoarthritis	☐	☐	Rheumatoid Arthritis
☐	☐	Osteoporosis	☐	☐	Gout	☐	☐	Depression	☐	☐	Bipolar
☐	☐	Schizophrenia	☐	☐	Neuropathy	☐	☐	Alcoholism	☐	☐	HIV/Aids
☐	☐	Cancer	☐	☐	Low Back Pain	☐	☐	Serious Injury	☐	☐	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**
[ ] Spine Surgery (neck or back)	_____	[ ] Appendix	_____
[ ] Disc Surgery (neck or back)	_____	[ ] Gallbladder/Stomach/Kidney	_____
[ ] Heart	_____	[ ] Cancer (any type)	_____
[ ] Tonsillectomy	_____	[ ] Rib/Collar Bone	_____
[ ] Head/Brain	_____	[ ] Hernia	_____
[ ] Shoulder/Arm/Leg	_____	[ ] 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: _____

_____

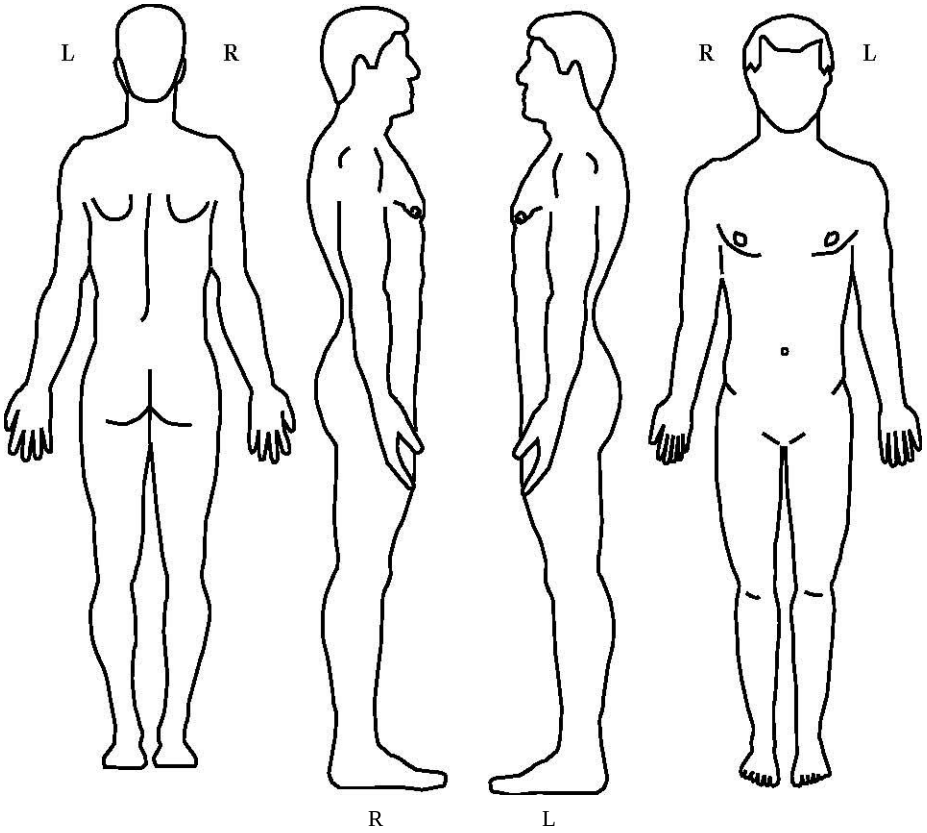
Family History: Please check any problems that run in your family.

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Heart Attack	☐	☐	Heart Trouble	☐	☐	Asthma	☐	☐	Diabetes
☐	☐	Stroke	☐	☐	Aneurysm	☐	☐	Gout	☐	☐	Kidney Trouble/Stones
☐	☐	Bleeding Disorder	☐	☐	Arthritis	☐	☐	Alcoholism	☐	☐	Mental Illness
☐	☐	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: _____