

# Welcome

## Patient Information

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Insurance

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_

Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## Phone Numbers

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_

## Accident Information

Is condition due to an accident?  Yes  No

Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?  
 Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_

## Patient Condition

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

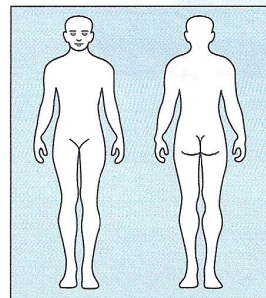
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down



## Health History

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy  
 Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_  
 Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_  
 Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |                     |                              |                             |                  |                              |                             |                      |                              |                             |                    |                              |                             |
|---------------------|------------------------------|-----------------------------|------------------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|
| AIDS/HIV            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Migraine             |                              |                             | Rheumatic Fever    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcoholism          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emphysema        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headaches            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scarlet Fever      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergy Shots       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Miscarriage          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fractures        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mononucleosis        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Suicide Attempt    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anorexia            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Multiple Sclerosis   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Appendicitis        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Goiter           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mumps                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsillitis        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gonorrhoea       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoporosis         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gout             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumors, Growths    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorders  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parkinson's Disease  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Typhoid Fever      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breast Lump         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pinched Nerve        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bronchitis          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hernia           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pneumonia            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vaginal Infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bulimia             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herniated Disk   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Polio                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herpes           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prostate Problem     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Whooping Cough     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cataracts           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prosthesis           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other _____        |                              |                             |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____              |                              |                             |
| Chicken Pox         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____              |                              |                             |
|                     |                              |                             | Measles          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                      |                              |                             |                    |                              |                             |

### EXERCISE

- None  
 Moderate  
 Daily  
 Heavy

### WORK ACTIVITY

- Sitting  
 Standing  
 Light Labor  
 Heavy Labor

### HABITS

- Smoking  
 Alcohol  
 Coffee/Caffeine Drinks  
 High Stress Level

Packs/Day \_\_\_\_\_  
 Drinks/Week \_\_\_\_\_  
 Cups/Day \_\_\_\_\_  
 Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

### Medications

### Allergies

### Vitamins/Herbs/Minerals

_____ _____ _____ Pharmacy Name _____ Pharmacy Phone (____) _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
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## Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

### 1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
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### 2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
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### 3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance
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### 4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips
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### 5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work
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### 6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
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### 7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day
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### 8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
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### 9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking
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### 10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing
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Name \_\_\_\_\_

PRINTED

Signature \_\_\_\_\_

Date \_\_\_\_\_

# WHITE HOUSE CHIROPRACTIC

## Consent for Use or Disclosure of Health Information

### Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice (which describes our privacy practices in detail) before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

### Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

### Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. A copy of the Notice of Privacy Practices for Protected Health Information is available if I request a copy.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

- I ACCEPT A COPY OF THE FULL PRIVACY NOTICE (4 PAGES)
- I DECLINE A COPY OF THE FULL PRIVACY NOTICE (4 PAGES)