



PATIENT INFORMATION FORM

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

Social Security Number [] [] [] [] [] [] [] [] [] Birth Date: ___/___/___ Age: ___ Gender: F M

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ___/___/___ Phone: (____) _____

Mother: _____ Date of Birth: ___/___/___ Phone: (____) _____

Guardian / Foster Parent: _____ Date of Birth: ___/___/___ Phone: (____) _____

Who do you normally live with (check all that apply)? [] Father [] Mother [] Guardian / Foster Parent [] None of These

Marital Status: [] Married [] Separated [] Widowed [] Single How many children? _____

CURRENT ADDRESS OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home)

Street _____ Street _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Phone (____) _____ Phone (____) _____

Email Address: _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (____) _____

Student at _____ [] FULL-TIME [] PART-TIME

Who should we contact in the event of an emergency? _____ Phone (____) _____

Address of contact person _____

Who may we thank for the referral or how did you learn about us? _____

Is your condition or injury due to an accident or work-related cause? [] YES [] NO Please check ALL that apply.

Did the condition or injury result from automobile accident? [] YES [] NO

Did it result from a work-related accident or cause? [] YES [] NO (briefly describe): _____

Approximately, when did your injury or condition occur? ___/___/___

Primary Care Physician: _____ May we contact your doctor regarding your condition? [] YES [] NO

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/___

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/___

Financial Responsibility

Who is financially responsible for your care: [] Health Insurance [] Auto Insurance [] Worker's Compensation [] Self

If this is through your health insurance: List Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/___ Does the policy holder have the insurance through his/her employer? [] YES [] NO If yes, who is the employer? _____

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/___

Fisher Chiropractic & Integrative Health

Health Insurance Election

(Accident and Non-Accident Cases)

How would you like for us to handle your health insurance? Please choose one:

Option 1 -- I Want You to File My Health Insurance and Also to Help Me Verify My Benefits. To Help You Get Paid, I'll Make Partial Payments and/or Sign an Assignment & Financial Policy

I want the services we discuss, but I also want you to bill my health insurance for an official decision on payment even if this is an accident case. Please help me verify any Terms of Non-Coverage. If I have any questions, I will verify my coverage on my own. You may ask to be paid now or later for estimated co-pays, co-insurance, deductibles and other Non-Covered amounts. I understand that these are just estimates. If my condition is due to an accident case, I would ask that you delay from collecting such amounts as described in your Financial Policy. With this in mind, I agree to the terms of the Financial Policy. In the event that my health insurance delays or Denies Payment, I will be responsible for payment as described in the Financial Policy, but I understand that I will be able to appeal to my health insurance following its directions.

Option 2 -- I Do Not Have Health Insurance / I Don't Want You to File My Health Insurance

I want the services we discuss, but either I don't have health insurance or I don't want you to bill or submit paperwork to my health insurance. You may keep any health insurance, which I do have, on file as set forth in your Financial Policy. You may ask to be paid now or later as I am responsible for payment. I understand that if my claims or forms are not submitted to my health insurance in a timely manner, my payer may decline to pay on my claims and I may not be able to appeal this decision.

Option 3 -- I Want You to File My Health Insurance, But I'll Pay in-Full at the Time of Service or Pre-Pay. If Insurance Pays, You'll Give Me a Refund

I want the services we discuss, but I also want you to bill my health insurance for an official decision on payment. However, you may ask to be paid now. If my health insurance does pay, you will refund any payments I made to you, less co-pays, co-insurance, and deductibles, and also discounts (Mandatory Fee Reductions) as described in your Financial Policy. In the event that my health insurance Denies Payment, I can appeal to my health insurance following its directions.

Important: I understand that in certain circumstances, the Office may have a policy of not filing health insurance or law may actually control or regulate the filing of insurance. This election will remain in effect until a new election is signed with the Office's consent. This election supersedes any prior health insurance election.

Patient Signature: _____ Date: ___/___/___

Patient Name: _____



Adult Health History Form

Your answers on this form will help us better understand your concerns and conditions better. If you cannot remember specific details, please provide your best guess. **Thank you!**

Age _____ How would you rate your general health? Excellent Good Fair Poor

In order of importance, please list the problems you are interested in having corrected.	How long has this been an issue?
1.) _____	_____
2.) _____	_____
3.) _____	_____
4.) _____	_____

Is there a time when these problems feel better or worse? _____
Please describe any sudden movements, falls, accidents, etc that have caused your problem(s)?

Have you had similar problems in the past? Yes No _____
Names of other providers or any other therapies: _____

Have your health problems Improved Stayed the same Have Become Worse
What makes them better? _____ Worse? _____
Please indicate how this problem interferes with your personal/work life:
 Work Activities Effected: _____
Have you missed any days of work? Yes No If yes, dates missed: _____
 Home Activities Effected: _____
 Recreational Activities Effected: _____

PREVIOUS MEDICAL HISTORY

During the past year, has a Doctor treated your for a health problem? Yes No
If YES, please explain: _____

Have you ever received chiropractic care? Yes No If YES, please list the Doctor, for what problems and outcome:

MEDICATIONS: Prescription and non-prescription medications, vitamins, home remedies, birth control pills, herbs, etc. _____

Allergies or reactions to medications: _____

MAJOR MEDICAL EVENT HISTORY: Please list all procedures, complications (if any), and dates:
Year Surgery, Illness, Injury Outcome

***Circle any of the following topics that interest you or you would like more information on:**
Acupuncture Functional Nutrition Improving your Golf Game Massage Therapy
Custom Orthotics Physical Rehabilitation Improving Your Health

REVIEW OF SYSTEMS: Please check any current symptoms you have.

Constitutional ___ Recent fevers/sweats ___ Unexplained weight loss/gain ___ Unexplained fatigue/weakness Eyes ___ Change in vision Ears/Nose/Throat/Mouth ___ Difficulty hearing/ringing in ears ___ Hay fever/allergies/congestion ___ Trouble swallowing Cardiovascular ___ Chest pains/discomfort ___ Palpitations ___ Short of breath with exertion Allergies ___ Hay fever ___ Food Allergies List: _____	Respiratory ___ Cough/wheeze ___ Coughing up blood Gastrointestinal ___ Heartburn/reflux ___ Blood or change in bowel movement ___ Nausea/vomiting/diarrhea ___ Pain in abdomen Genitourinary ___ Painful/bloody urination ___ Leaking urine ___ Nighttime urination ___ Discharge: penis or vagina ___ Unusual vaginal bleeding ___ Concern with sexual functions Endo ___ Cold/heat intolerance ___ Increase thirst/appetite	Skin ___ Rash ___ New or change in mole Neurological ___ Headaches ___ Memory loss ___ Fainting ___ Numbness/Tingling ___ Dizziness Musculoskeletal ___ Joint Pains, Swelling or Stiffness ___ Redness, heat or muscle pain Blood/Lymphatic ___ Unexplained lumps ___ Easy bruising/bleeding
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FAMILY HISTORY: Please indicate the current status of your immediate family members (parent, sibling, grandparent, aunt, or uncle) with any of the following conditions:

Genetic disorders	High cholesterol
Cancer, specify type	High blood pressure
Heart disease	Stroke
Depression/suicide	Bleeding/clotting disorder

SOCIAL HISTORY:

In the past month, have you had little pleasure in doing things, or felt, depressed, anxious or hopeless? Yes No

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Do you smoke? Yes No If yes, how many packs/day? _____

Do you drink? Yes No If yes, how many drinks/day? _____

Do you exercise regularly? Yes No If yes, what type and how often?

Do you consider yourself to have a good social support system (family/friends)? Yes No

Describe a typical diet (only include meals snacks you regularly eat):

Breakfast: _____ Snack: _____

Lunch: _____ Snack: _____

Dinner: _____ Snack: _____

Is there anything else concerning your health that you think is important that was not asked elsewhere on this form? _____

Do you have any other health goals you would like to accomplish? _____

(feel free to continue on the back of this sheet)

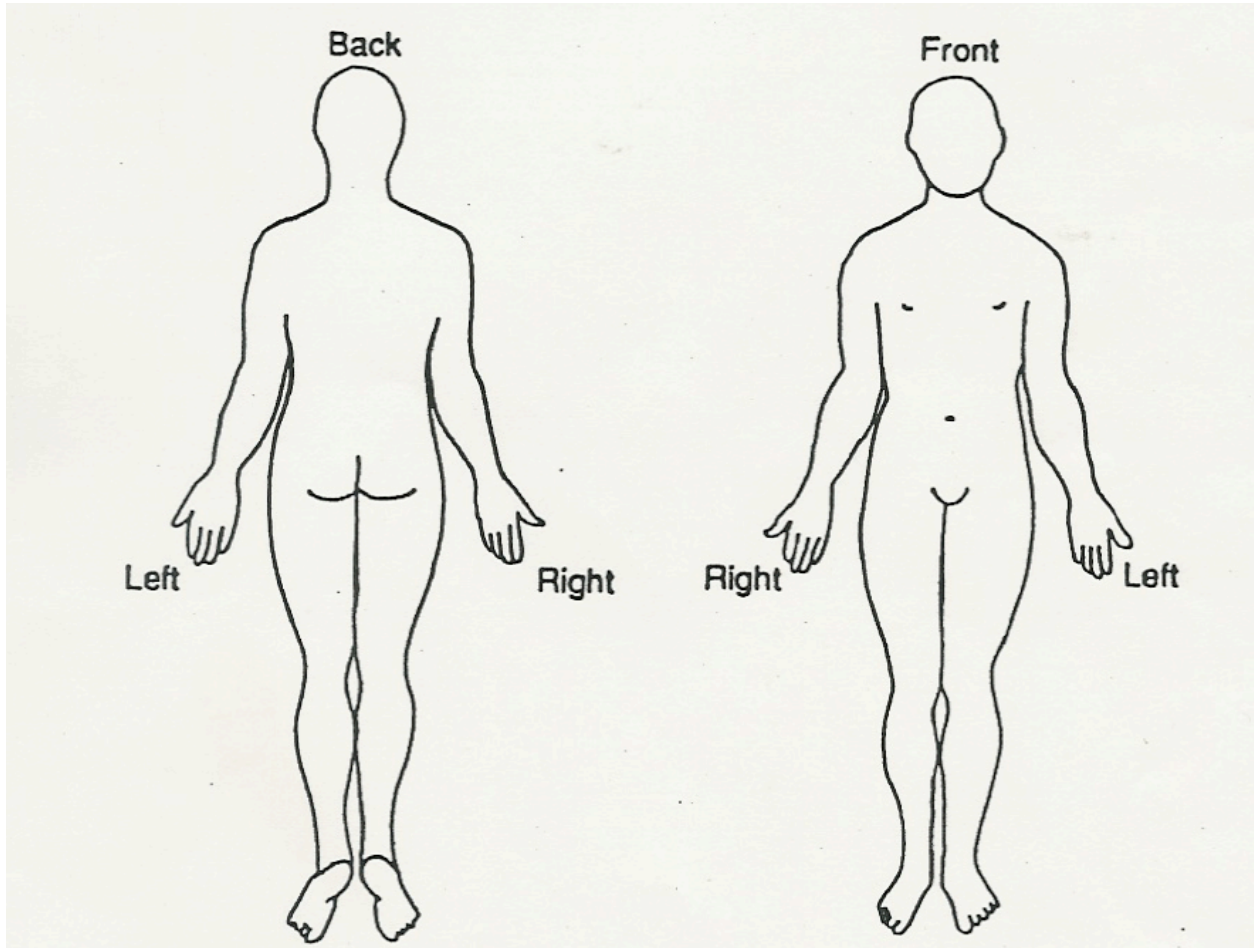
PAIN DIAGRAM

Name: _____ Date: _____

Please use the symbols below to show the area, upon the body outlines, in which you are experiencing pain.

Ache-A
Burning-B
Numbness-N

Pins and Needles-P
Stabbing-S
Other-O



The line below represents the intensity of the pain you are experiencing. Please make an "X" at the position on the scale which indicates how much pain you are feeling **at this time**.

Date: _____

