CHIROPRACTIC PATIENT UPDATE

OFFICE USE: Patient #___________
Doctor: ______________________

Please complete Parts A & C in all cases. Part B should be completed only if the information has changed since you were last in our office.

Thank You!

PART A

Name: _______________________________________ D.O.B____/_____/______ Today's Date: ____________________

Address: ____ City: _________________ State: ______ Zip: ________

Home Phone: __________________ Cell Phone: _________________ Email: ___________________________________

Purpose of this appointment: ____

Is this the same problem you were originally under care for? ( ) Yes ( ) No

If yes, are there any additional symptoms? ____

Have you noticed any improvement? ( ) Yes ( ) No

What medications or supplements are you currently taking? ____

____

PART B

Occupation: ________________________________ Employer: ____

Work Address: ____ Work Phone: _________________________

Emergency Contact: ____________________________ Relationship: __________________Phone #: ________________

Spouse: ____ Spouse's Employer: __________________________________

Name of Primary Insurance Company: ____

Name of Secondary Insurance Company (if applicable): ____

PART C

AUTHORIZATION & RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow Coastline Chiropractic and Rehabilitation Center to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

Name: ____ **Name:** ____

Patient's Signature: ____ Date: _________________

Guardian's Signature Authorizing Care: ____ Date: _________________

COASTLINE CHIROPRACTIC
AND REHABILITATION CENTER

1) What is your major symptom? ____

2) If this is a recurrence, when was the first time you noticed this problem? ____________________________

How did it originally occur? ____

Has your condition worsened? ( )Yes ( )No If yes, how and when? ___________________________________

Is your condition: ( )The Same ( )Better ( )Gradually Worse

3) How Frequent is this condition? ( )All Day ( )A Few Hours ( )Minutes

4) Are there any other conditions or symptoms that may be related to your major symptom? ( ) Yes ( ) No

If yes, please describe: ____

5) Are there other unrelated health issues? ( ) Yes ( ) No If yes, please describe: __________________________

____

6) Describe the pain: ( )Dull ( )Sharp ( )Numbness ( )Tingling ( )Aching ( )Burning ( )Stabbing

( )Throbbing ( )Other, please describe: ____

7) Is there anything you can do to relieve the problem? ( ) Yes ( ) No If yes, please describe: ______________

____

8) Do any of the following worsen your condition? ( )Standing ( )Sitting ( )Lying ( )Bending ( )Lifting

( )Twisting ( )Other, please describe: ____

9) Have you had any broken bones? ( ) Yes ( ) No If yes, please list and give dates: ________________________

____

10) Please list any major accidents that were not previously listed above with dates of occurrence:______________

____

11) To your knowledge, have you had any diseases, illnesses or injuries not previously listed above? ( ) Yes ( ) No

If yes, please explain: ____

12) WOMEN ONLY: Are you currently pregnant? ( ) Yes ( ) No ( ) Uncertain

13) Remarks:____

14) Please rate your level of discomfort (Please circle one): (None) **1 2 3 4 5 6 7 8 9 10** (Extreme)

Patient/Guardian Signature: ____ Date: ___________________

Doctor's Signature: ____ Date: ___________________