SNYDER CHIROPRACTIC CARE

CONFIDENTIAL PATIENT INFORMATION Date: _____

Patient's Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ Zip: _____ Cell Phone Carrier_____

Birth Date_____Race:_____Language:_____Email:_____

Marital Status: M S W D Spouse's Name: _____

Occupation: _____ Employer: _____

Height: _____feet _____inches **Weight** _____lbs

Person to contact in case of an emergency (Name and Phone #): _____

Are your present symptoms or condition related to, or the result of, an **auto collision, work-related injury, or other personal injury** (someone else might be responsible for payment)? ____YES____NO

Who **referred** you to our office? _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ **Name of Policy Holder**: _____

Relationship to the patient _____ **Policy Holder's DOB**: _____

Policy Holder's Address **(if different from the patient's):**

_____

Policy Holder's Employer: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ **Name of Policy Holder**: _____

Relationship to the patient _____ **Policy Holder's DOB**: _____

Policy Holder's Address **(if different from the patient's)**:

_____

Policy Holder's Employer: _____

MAIN PROBLEM

What pain causes you to come to the office **today**? _____

When did the pain start? _____ What caused the pain? _____

How often does the pain occur? (circle one) **Occasional Frequent Constant**

On a scale of 1-10, how bad is the pain? (circle one) 1 2 3 4 5 6 7 8 9 10

Does the pain travel to any other area(s)? (circle one) YES NO If yes, where? _____

What makes the pain better? (circle) Ice Heat Stretching Rest

What makes the pain worse? (circle) Bending Lying Walking Standing Sitting Movement Twisting Lifting

What have you done to treat this pain? _____

Are there any other problems you would like to discuss with the doctor? _____

MEDICATIONS

Please list **all** medications you are currently taking including the dosage, frequency taken, and the **REASON** you are taking it:

_____

_____

_____

ALLERGIES

Do you have any allergies? (circle one) YES NO

Please list **(INCLUDE REACTION):**

_____

_____

FAMILY HISTORY

Please tell us about the health of your parents, grandparents, and siblings. Circle everything that applies, and write **RELATIONSHIP** below:

Heart Disease Stroke Cancer Diabetes Rheumatoid Arthritis Multiple Sclerosis

_____

Have you ever been under Chiropractic Care? (circle one) YES NO

If so, who and when?_____

Have you had any **SPINAL X-Rays/ MRI's/ CT's** taken in the last year? (circle one) YES NO

If so, where? _____

Do you have a **PACEMAKER/DEFIBULATOR**? (circle one) YES NO

Have you ever had any **Hip/Knee Replacements**?(circle)Left Hip Right Hip Left Knee Right Knee

Do you smoke? (circle one) YES NO Would you like information on quitting? (circle one) YES NO

I certify that the information that I have given here is true and accurate to the best of my knowledge.

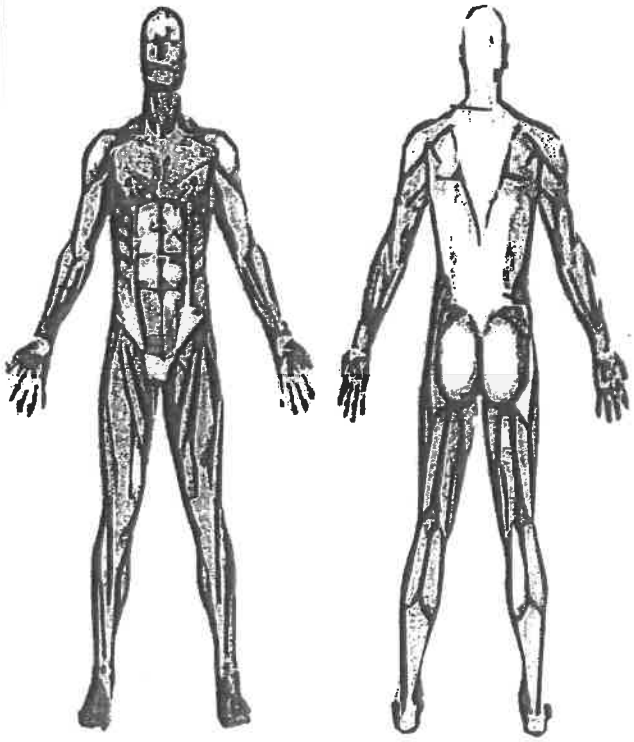
Signed _____ ***Date*** _____

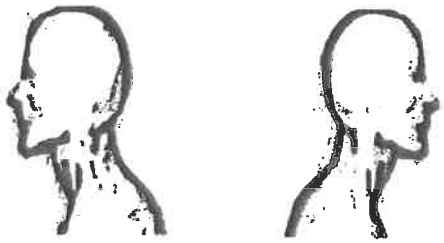
Have you ever suffered from:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache	O=Other
B=Burning	P=Pins & Needles
N=Numbness	S=Stabbing





SIGNATURE PAGE

The above information is true and to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any and all balances due and am liable for any collection and or legal fees. I also authorize Snyder Chiropractic Care Inc. to release any information required to process my claims.

CONSENT FOR CHIROPRACTIC TREATMENT

I hereby authorize and direct Dr Patrick Snyder, with the assistant(s) to preform chiropractic procedures on myself / child, as we have agreed upon.

- The nature and purpose of the treatment to be preformed are: Chiropractic Adjustments/Therapies.
- These treatments are expected to accomplish: increase range of motion and decrease muscle spasms along with reduction of pain.
- The reasonable known risks of adjustments are: initial stiffness and discomfort.
- Details of this treatment and alternative methods of treatment have been explained to me. I have been advised that, although good results are expected each situation/person reacts differently to treatment; therefore, the outcome of treatment has no guarantee as expressed or implied.
- The doctor has explained to me the most likely complication that may occur from treatment and I understand them. I have also been told the less likely, even rare, that could occur.
- I will not record my visit (video or audio) without the expressed written consent from the physician.
- I hereby authorize Dr Patrick Snyder and his assistant(s) to provide additional procedures as they deem reasonable and necessary, including but not limited to, x-ray and therapy.
- I hereby affirm and state that I have read and understood this consent with my signature.

MEMO ON HIPAA

As you may know, we are required by law to have you sign a statement that you know your rights on protecting your privacy. If requested we do have on hand the "Notice of Privacy Practices" handout. Please sign below indicating that you were offered a copy.

POLICY ON LATE AND NO SHOW APPOINTMENTS

We know how important your time is. We do our best to stay on schedule. If you know that you will not be able to keep your scheduled appointment, please call the office (leave a message if necessary) as soon as possible. If you know that you may be late to your scheduled appointment, please call as soon as possible to let us know. We will charge a **fee of $25** (Not Covered by Insurance) if you are a **NO Show/ No Call.** If you are more than **15 minutes late** for your appointment, you may be required to reschedule.

By signing below I acknowledge that I have read and understand the policies above.

Signature_____ ***Date***_____

Minor Child Relationship_____