PATIENT INFORMATION

Date: _____ Full Name: _____

Preferred name/nickname: _____ Date of Birth: _____ Age: _____

Sex: M F Marital Status: S M D W Social Security#: _____

Home Ph#: _____ Cell Ph#: _____ Work Ph#: _____

Best daytime number to reach you: Home Cell Work Is it ok to leave a message? Yes or No If so, which numbers and with whom? _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Email: _____ Would you like to receive email or text notifications? (ex. Appointment reminders, administrative updates, and health bulletins) Yes or No

Emergency Contact: _____ Phone: _____ Relation: _____

Spouse's name: _____ Phone: _____

INSURANCE INFORMATION

Insurance company: _____ Phone#: _____
Insured's name: _____ ID/Policy#: _____

Insurance company: _____ Phone#: _____
Insured's name: _____ ID/Policy#: _____

OTHER INFORMATION

Current Complaint: _____

Are you here as a result of an injury? Y N Accident Date: _____

Accident Type: Auto Work Home Recreation Sports Other None

MY CERTIFICATION

I certify that the above information is true and correct. By signing, I give consent to Poelking Chiropractic Wellness & Physical Therapy, Inc to call my home or other designated number and leave a message, mail to my home or send to my email any and all items that assist in carrying out treatment, payment and healthcare operations unless specifically declined above.

_____ _____
Signature of Patient or Patient's Representative Date

Patient:_____ Date of Birth:_____

FINANCIAL RESPONSIBILITY

I understand that I am personally **financially responsible** for all services provided to me by Poelking Chiropractic Wellness & Physical Therapy, Inc. which may include any annual deductibles, copays, or non-covered services as may be required by my insurance plan if applicable. I authorize the release of all information necessary to communicate with personal physicians, other health providers, collection agencies and payers to secure payment of benefits or to inform them of concurrent treatment.

_____ _____

Signature of Patient or Patient's Representative Date

MY PRIVACY

I have received a copy (or a copy has been made available to me) of the **Notice of Privacy Practices** of Poelking Chiropractic Wellness & Physical Therapy, Inc. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment, obtain payment from third-party payors, conduct normal healthcare operations such as quality assessments and accreditation.

_____ _____

Signature of Patient or Patient's Representative Date

COMPLAINT FORM

CHIEF COMPLAINTS:

Please explain the reason(s) that prompted you to come to this office for treatment in the spaces below. (Example: "Lower back pain, Neck pain, Numbness in the right leg, etc...)

1. _____

_____

Rate your pain: My pain is a: 1 2 3 4 5 6 7 8 9 10 (Please Circle)

The complaint came on: Gradually Immediately

It is getting: Better Worse Staying the same

The Intensity is: Minimal Moderate Severe

The Frequency is: Occasional Frequent Constant

Describe the pain: Sharp Dull Achy Shooting Burning Throbbing
tingling Spasming Stiff

Location: Right Left Middle Both sides

2. _____

_____

Rate your pain: My pain is a: 1 2 3 4 5 6 7 8 9 10 (Please Circle)

The complaint came on: Gradually Immediately

It is getting: Better Worse Staying the same

The Intensity is: Minimal Moderate Severe

The Frequency is: Occasional Frequent Constant

Describe the pain: Sharp Dull Achy Shooting Burning Throbbing
Tingling Spasming Stiff

Location: Right Left Middle Both sides

3. _____

_____

Rate your pain: My pain is a: 1 2 3 4 5 6 7 8 9 10 (Please Circle)

The complaint came on: Gradually Immediately

It is getting: Better Worse Staying the same

The Intensity is: Minimal Moderate Severe

The Frequency is: Occasional Frequent Constant

Describe the pain: Sharp Dull Achy Shooting Burning Throbbing
Tingling Spasming Stiff

Location: Right Left Middle Both sides

Is there anything that helps your condition? (Example: Ice, rest, lying down, heat, medication...)

_____

What makes your condition worse: _____

PAST MEDICAL HISTORY:

Please explain any and all medical conditions that you current suffer or have suffered from in the past. (example: Heart disease, Diabetes, Cancer...)

1. _____
2. _____
3. _____
4. _____
5. _____

PAST SURGICAL HISTORY:

List any surgeries below:

1. _____
2. _____
3. _____
4. _____
5. _____

ALLERGIES:

List any known allergies below:

1. _____
2. _____
3. _____

4. _____

5. _____

FAMILY HISTORY:

List any relevant family history below:

1. _____

2. _____

3. _____

4. _____

5. _____

MEDICATIONS:

List any and all medications you are currently taking below:

1. _____

2. _____

3. _____

4. _____

5. _____

SOCIAL HISTORY:

Are you: SINGLE MARRIED WIDOWED DIVORCED SEPARATED

Do you have any children? YES NO If yes, how many? _____

Are you pregnant? YES NO If YES, what month?_____

Do you use: TOBACCO ALCOHOL COFFEE - (Occasionally or Frequently?)

If yes for tobacco, are you: CURRENTLY USING QUIT

If currently using, what year did you start? _____ Quit: _____

You may return this form to the front desk. Thank you for taking the time to fill it out thoroughly.