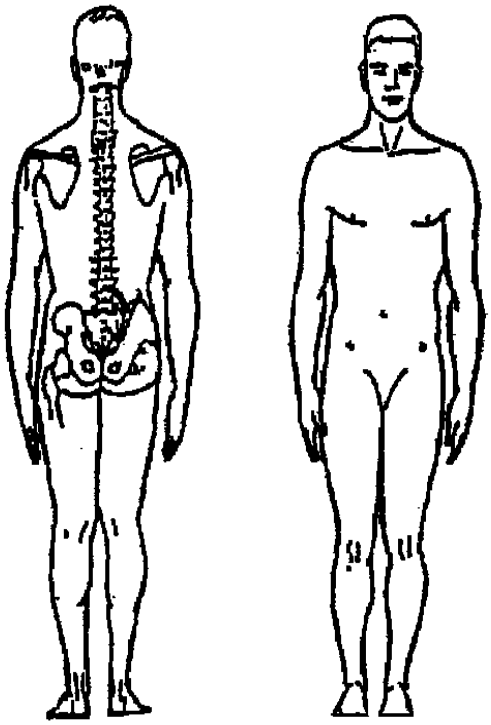
Rhodes Chiropractic
Case History/Patient Information

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. ***PLEASE PRINT***.

Acct. # _____ Today's Date _____
Name _____ Home Phone _____ Work Phone _____
Cell Phone _____ E-Mail Address_____
Address _____ City _____ State _____ Zip _____
Birth date _____Marital Status: S M W D Number of Children _____
Your Employer _____ Occupation _____
Employer Address _____ City _____ State _____ Zip _____
Your Social Security # _____Name of Spouse or Parent _____
Spouse Employed By _____Occupation _____
Employer Address _____ City _____ State _____ Zip _____
Phone # _____



Emergency Contact: _____ ***Phone:***_____

*__*Circle area of complaint on the diagram to the left.*__

MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)

_____
_____
_____

Date Symptoms appeared or accident happened:_____
Have you ever had the same or similar condition? Yes or No
If yes, when and describe:_____

Referred to our office by: _____
Is your condition due to an accident? Yes _____ No _____ Date of accident? _____

Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____
Have you ever been in an auto accident? Past Year ____ Past 5 Years ____ Over 5 Years ____ Never ____

Insurance:

Please check any and all insurance coverage that may be applicable in this case:
Major Medical_____ Worker's Compensation_____ Medicaid_____ Medicare_____ Auto Accident_____
Medical Savings Account/Flex Plans_____Other_____

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company:_____

How will payments be made:

Cash_____Check_____Credit Card_____

PAST MEDICAL HISTORY:

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder
__Circulatory Problems	__Epilepsy	__Alcoholism
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction
__Seizures/Convulsions	__Strokes	__HIV Positive
__A Congenital Disease	__Cancer	__Gall Bladder
__Excessive Bleeding	__Ruptures	__Depression
__High/Low Blood Pressure	__Coughing Blood	__Ulcers

Do you have a history of stroke or hypertension (high blood pressure)? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? π Yes π No

If yes, describe:_____

Please list any other health problems you have, no matter how insignificant they may be:_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?___ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list:_____
Do you consume caffeine?____ If so, how much per day:_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting_____ sitting_____ bending_____working at a computer_____

***AUTHORIZATION AND RELEASE*: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office physicians to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I have received a current copy of Rhodes Chiropractic financial policy.**

The patient understands and agrees to allow this chiropractic office 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. If there is anyone you do not want to receive your medical records, please inform our office.

I authorize Rhodes Chiropractic to release any and all medical records, x-ray reports, and account information to the following person(s):

1. _____
2. _____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____