Scott Wagner CHIROPRACTIC and Sports Medicine

WHOO'S GOT YOUR BACK?

Welcome to our 5 star award winning office. Your ultimate chiropractic experience is about to begin.

Personal Information

Name: _____ Email: _____ Today's Date: _____

Date of Birth: _____ Phone #'s: _____

Address: _____ City: _____ Zip: _____

Occupation: _____ Employer: _____

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

Emergency Contact Name and Phone Number: _____

How were you referred here? _____

Have you been to a chiropractor before? _____ If yes, last adjustment? _____

Health History

Chief Complaint: _____

Date symptoms started: _____

Were you in a recent auto accident? _____ Date: _____

Past Medical History

Date of last physical: _____ Fam. Dr. _____

Have you ever suffered from:

- broken bone
- heart disease
- pacemaker
- kidney disease
- coughing blood
- asthma
- gall bladder
- circulatory problems
- high/low blood pressure
- ulcers
- arthritis
- liver disease
- depression
- alcoholism
- HIV positive
- epilepsy
- cancer
- stroke
- lung desease
- ADD/ADHD
- eating disorder
- drug addiction
- seizures

Have you ever had any major illnesses, falls, or surgeries? Women, please list childbirth information:

_____

_____

Have you been treated for other health conditions in the last year? _____

If yes: _____

Please list any medications currently taking:
_____
_____
_____

Are you have allergies of any kind? _____

Social History

Do you drink alcohol? _____ How many drinks per week? _____

Do you smoke or use tobacco products? _____ How much? _____

Do you take vitamins? ____ If yes, please list: _____

Do you exercise? _____ What frequency? _____

What % of time do you spend: sitting _____ working at computer _____ lifting _____

Family History

Do you have any family members that suffer from the same condition as you do? _____
If yes, their name so we can give you information to improve their quality of life.

Name: _____

Please list any history of family disease: Mother _____

Father _____Brother _____ Sister_____

Women Only: Are you pregnant or is there a possibility you could be pregnant? _____

Insurance: _____ Please present card so we can get a copy.

AUTHROIZATION AND 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. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.

Patient Signature: _____ Date: _____

HIPPA: The undersigned does hereby acknowledge that he/she has received a copy of this office's Notice of Privacy Pursuant to HIPPA and has been advised that a full copy of this compliance manual is available upon request.
The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPPA, the HIPPA Compliance Manual, State Law and Federal Law.

Patient Signature: _____ Date: _____