Confidential Patient History **Date** _____

Name_____ **Address**_____

City _____**State** _____ **Zip** _____ **Home Tel#** _____

Marital status (M D S W) Spouse _____ **# of Children** _____

Employer _____ **Work Phone #**_____**Cell** _____

Email _____ **Who referred you?** _____

How did you hear about our office? ___Our Website, ___Google, ___Yahoo, ___Yellow Pages, ___Ad(Please be Specific)_____

Social Security number _____ **Date of birth** _____

Purpose of appointment: Relief or Correction
Condition #1_____ **How Long?**_____
Condition #2_____ **How Long?**_____
Condition#3 _____ **How Long?**_____

Other doctors seen?_____ **Treatment** _____

Result? _____ **Accident?** _____ **When?** _____

Sleeping effected? _____ **Work effected?** _____ **Do you exercise?** _____

How would you describe your diet? Poor_____ **good** _____ **excellent** _____

How do you sleep ? **Poor** _____ **good** _____ **excellent** _____

How are you exercise habits? **Poor** _____ **good** _____ **excellent** _____

Are you taking medicine or drugs? _____

Drug/Purpose _____**Drug/Purpose**_____

Drug/Purpose_____**Drug/Purpose**_____

Drug/Purpose _____**Drug/Purpose**_____

Do you suffer from any other condition other than that which you are consulting us?

_____

Past Health History

Please list all surgeries, injuries, accidents, falls and date occurred.

_____ _____

_____ _____

_____ _____

_____ _____

Hospitalizations other than above _____

Have you had previous Chiropractic care? _____ Doctor? _____X-rays?_____

Date of last visit _____ Reasons _____

Please circle to indicate if you have had any of the following

Women: Are you Pregnant? Y/N Miscarriages? Y/N If yes, how many? _____

AIDS/HIV	Alcoholism	Allergy Shots	Anemia
Anorexia/Bulimia	Appendicitis	Asthma	Bleeding disorders
Breast Lump	Bronchitis	Cancer	Cataracts/Glaucoma
Chicken Pox	Diabetes	Emphysema	Epilepsy
Fractures	Gout	Heart Disease	Goiter
Hepatitis	Hernia	Herniated Disk	Herpes
High Cholesterol	Kidney Disease	Liver Disease	Migraine Headaches
Mononucleosis	Multiple Sclerosis	Mumps	Osteoporosis
Pacemaker	Parkinson's	Pneumonia	Polio
Prostate Problems	Psychiatric Care	Rheumatoid	Arthritis
Rheumatic Fever	Scarlet Fever	Stroke	Depression
Thyroid Problems	Tonsillitis	Tuberculosis	Tumors
Growths	Typhoid Fever	Ulcers	Venereal Disease
Whooping Cough	Chemical Dependency		

Pinched Nerve Where? _____ Prosthesis Where?_____

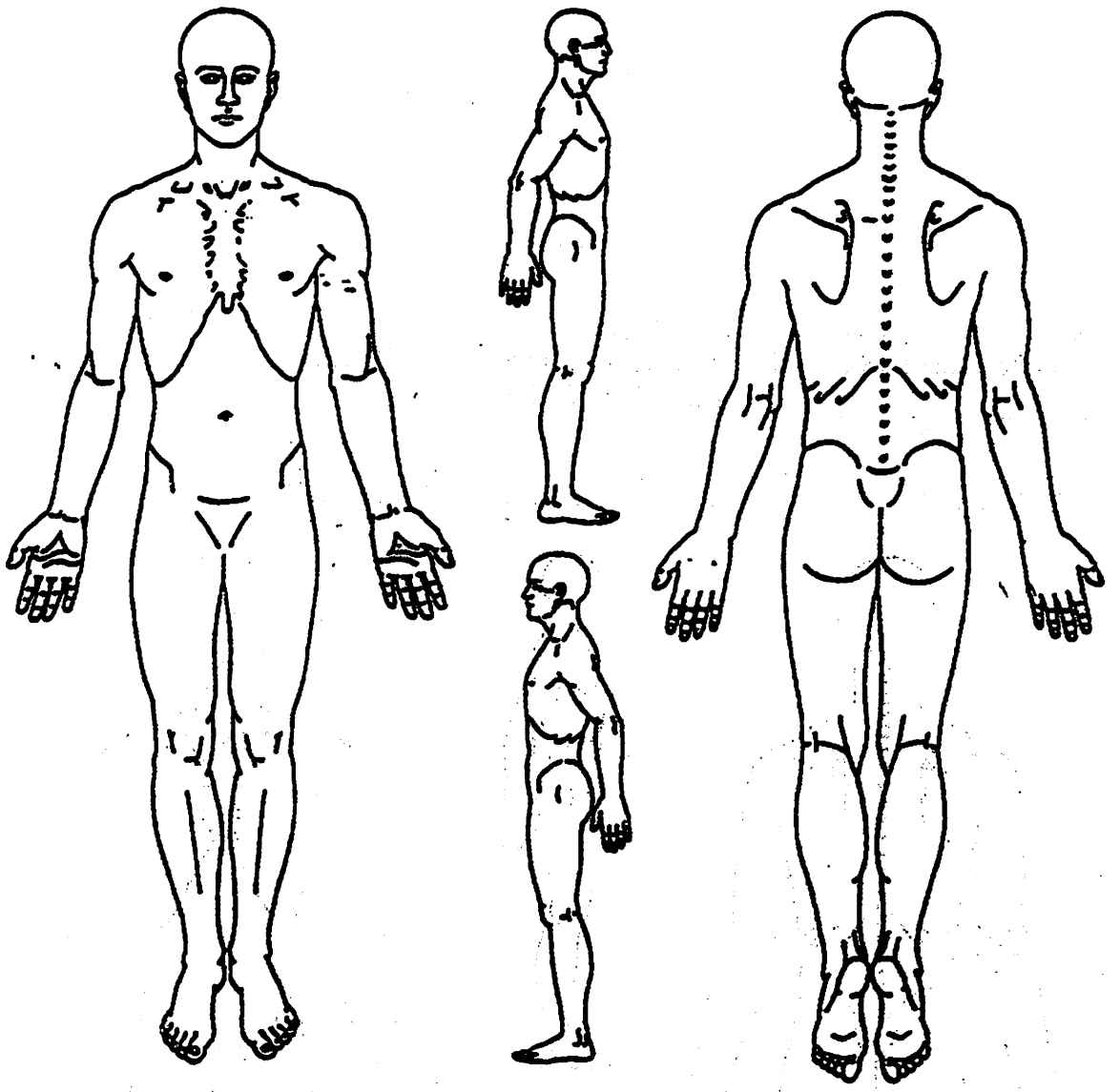
Other? (Ankle, Knee, Shoulder, Hip) _____

Patients Signature _____ **Date** _____

PAIN DRAWING

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

A =	**Ache**	**B =**	**Burning**	**R =**	**Radiating Pain**	**D =**	**Dull Pain**
N =	**Numbness**	**S =**	**Stabbing**	**P =**	**Pins & Needles**	**O =**	**Other**



Please indicate how you would rate your pain 0 1 2 3 4 5 6 7 8 9 10

Frequency of waking hours ( ) 0-25% ( )26-50% ( )51-75% ( )76-100%

NAME: (please print)_____

How long have you experienced neck/back pain? _____ Years _____ Months _____ Weeks

Is this your first episode of neck/back pain? _____ YES _____ NO

SIGNATURE:_____ DATE:_____

Phipps Chiropractic
1200 E Collins, Suite 108
972-437-5800

Please initial each statement below indicating you have read and understand.

____ I was NOT involved in an auto accident. I am NOT seeking treatment caused by any other party.

____ I was NOT involved in a work injury and I am NOT seeking treatment as a result of an injury on the job or by any other person related to my employment.

____ I want Phipps Chiropractic to file my medical insurance. I understand that there is no guarantee of payment by insurance and all fees are my responsibility.

____ I am NOT filing insurance.

____ I understand all appointments are reserved for me and it is my responsibility to contact Phipps Chiropractic within 24 hours of my appointment to reschedule or cancel. I understand that I am responsible for a $35.00 late fee for rescheduling and cancelling later than the 24 hour notice policy. This fee cannot be filed with insurance.

____ I have been given the opportunity to read the HIPPA policy provided by Phipps Chiropractic. I understand I can request a copy of the HIPPA policy for my own records.

____ I request and consent to chiropractic adjustments and other chiropractic procedures by the doctor of chiropractic and/or other licensed doctors and/or anyone working in this office authorized by the chiropractor. I understand chiropractic means hands on treatment by the doctor and/or staff. If I have an issue or reservations about being touched, it is my responsibility to inform the doctor and staff. I understand that, as in any medical facility, results are not guaranteed. I understand that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. I understand I have an opportunity to ask questions. I intend this consent to cover the entire course of treatment for my present condition and for any future conditions.

_____
Patient Name

_____ _____
Signature of Patient or Guardian Date