WELCOME

BERNARD CHIROPRACTIC CLINIC

PATIENT INFORMATION

Name _____ Birthdate_____Age_____

Address _____ City _____ Zip _____

Cell Phone _____Carrier(for text appt.reminders)_____

Email Address_____Home Phone_____

Occupation _____Employer _____

Employer address _____Work Phone_____

Marital Status: S M W D _____ Spouse Name_____

Who referred you? _____

HEALTH HISTORY

Purpose of this appointment (major complaint) _____

_____

Date symptoms appeared or accident happened _____

Is your condition due to an injury that occurred while on the job? Yes No

Have you ever had the same or similar condition? Yes No If yes, when and describe _____

Have you lost any days from work? Yes No If yes, how many _____

Females: Are you pregnant? Yes No Date of your last physical _____

What operations have you had? _____

Serious Illnesses? _____

Have you ever been under chiropractic care? Yes No How many yrs ago? _____

Other doctors seen for this condition? _____

What relieves your condition? _____

What treatments have you already tried for this condition? _____

_____

What aggravates your condition? _____

HEALTH HISTORY CONTINUED

Is this condition getting progressively worse? Yes No Constant _____ or

Comes and goes _____

Is this condition interfering with your: (circle) Work Sleep Daily Routine

Other _____ _____

What medications are you taking? _____

_____

Do you experience tingling or numbness in:

_____ Shoulders _____ Hips _____ Arms _____ Legs

_____ Elbows _____ Knees _____ Hands _____ Feet

Type of Pain:

_____ Sharp _____ Dull _____ Throbbing _____ Numbness

_____ Aching _____ Shooting _____ Burning _____ Swelling

_____ Tingling _____ Cramps _____ Stiffness

Rate the severity of your pain: (1 mild, 10 severe) 1 2 3 4 5 6 7 8 9 10

Remarks or additional information you would like the doctor to know:

_____

_____

I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination ordered to me or my child to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

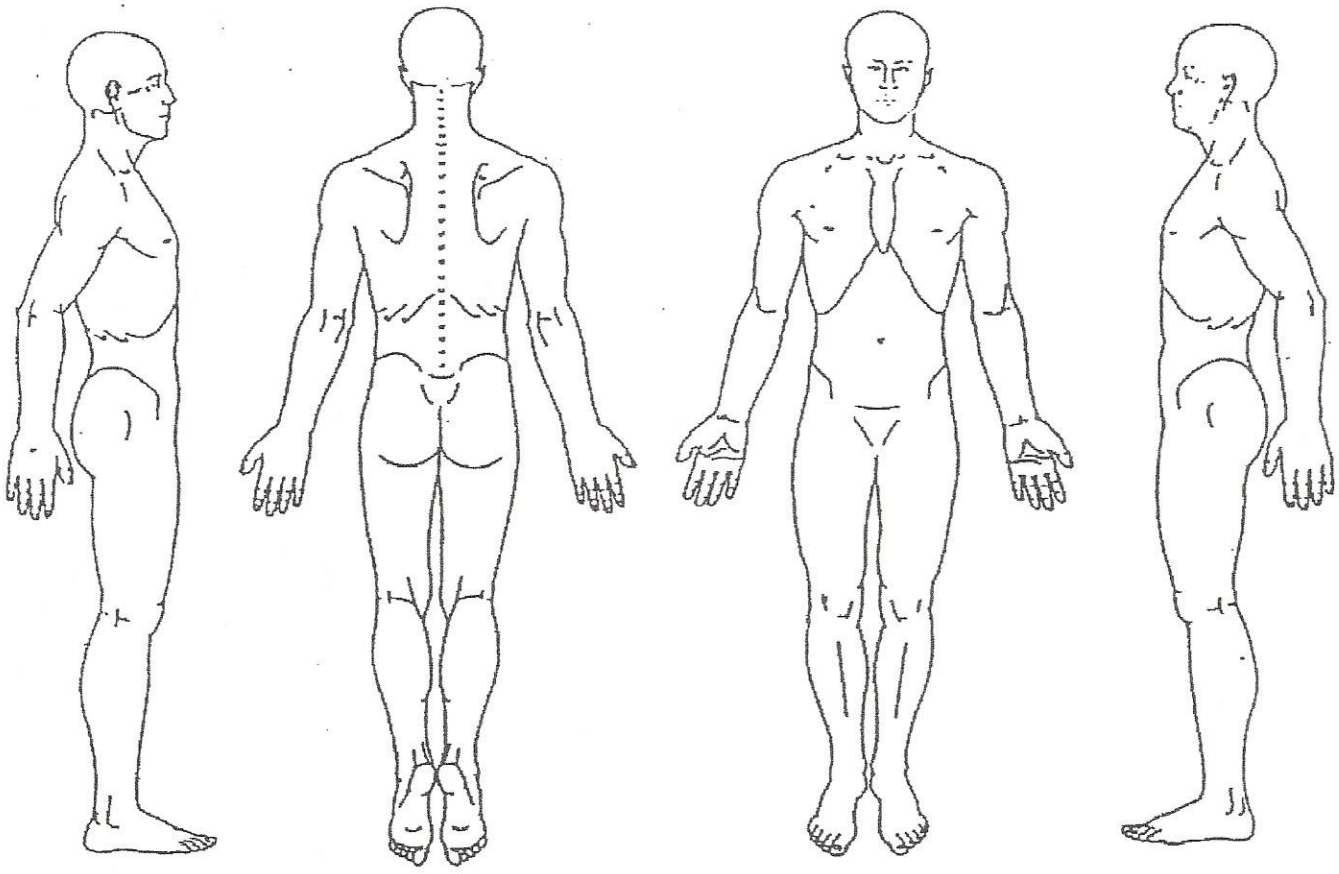
X _____ _____

Signature of patient (or parent if minor) Date

Name _____ Date _____

On the drawing below please indicate where you are experiencing pain. Please use the following letter abbreviations(s) that most accurately reflect the type of discomfort that you have been experiencing.

N = Numbness	T = Tingling	D = Dull Pain	P = Sharp Pain
B = Burning	S = Stiffness	C = Cramping	



Please place one mark on the line below to indicate your present pain level:

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain Ever

BERNARD CHIROPRACTIC CLINIC
2160 N. ALMA SCHOOL RD #102
CHANDLER, AZ 85224

Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand I can be provided (upon request) with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____ _____

Signature of Patient Date