Confidential

Health Information

All information you supply is confidential

On-Site Chiropractic
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www.theonsitechiro.com

_____
Patient Number(Office Use Only)

_____ Previous chiropractic care? ☐Yes ☐No _____
Today's Date (MM/DD/YYYY) Last chiropractic visit (MM/YYYY)_____ Previous Chiropractor's Name

_____ _____ _____ _____ _____
Last Name First Name Middle Initial Date of Birth (MM/DD/YYYY) Age

_____ _____ _____ _____
Birth Gender Current Gender Pronouns Ethnicity

_____ _____ _____ _____
Address City State Zip Code

_____ _____
Phone Number Email Address

Preferred Method of Contact (Mark all the apply): ☐Phone Call ☐Text Message ☐Email

_____
Emergency Contact Name Relationship Phone Number

_____
Primary Care Physician Name Phone Number

_____
Referring Physician Name Phone Number

Primary Complaint Symptoms

_____
_____
_____
_____

Most recent onset date:_____
Past Episodes of the same condition?
☐Yes ☐No Dates:_____
Highest pain level over past week

☺ 1 2 3 4 5 6 7 8 9 10 ☹

Average pain level over past week

☺ 1 2 3 4 5 6 7 8 9 10 ☹

What makes it better and worse?

_____
_____
_____

What have you tried so far to make this go away?_____

_____
_____
_____

Secondary Complaint Symptoms

_____
_____
_____
_____

Most recent onset date:_____
Past Episodes of the same condition?
☐Yes ☐No Dates:_____
Highest pain level over past week

☺ 1 2 3 4 5 6 7 8 9 10 ☹

Average pain level over past week

☺ 1 2 3 4 5 6 7 8 9 10 ☹

What makes it better and worse?

_____
_____
_____

What have you tried so far to make this go away?_____

_____
_____
_____

Additional Concerns

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Review of Systems (Mark off any conditions that you have had or are currently experiencing)

Pain in	☐Neck ☐Upper Back ☐Mid Back ☐Lower Back ☐Arms ☐Legs ☐Shoulders ☐Elbows ☐Hands ☐Hips ☐Knees ☐Feet ☐ None
Musculoskeletal	☐Scoliosis ☐Arthritis ☐Osteoporosis / Osteopenia ☐None
Neurological	☐ Headache ☐Pins and Needles ☐ Numbness ☐None
Cardiovascular	☐ High or Low Blood Pressure ☐High Cholesterol ☐Stroke ☐Poor Circulation ☐Angina ☐ Excessive Bruising ☐None
Respiratory	☐Asthma ☐Apnea ☐Emphysema ☐Shortness of Breath ☐None
Digestive	☐Anorexia/Bulimia ☐Ulcer ☐Food Sensitivities ☐Heartburn ☐Constipation ☐Diarrhea ☐None
Sensory	☐Vision ☐ Hearing ☐Ear Infections ☐Smell ☐ Taste ☐None
Skin	☐Skin Cancer ☐Psoriasis/Eczema ☐Acne ☐Rash ☐None
Endocrine	☐Thyroid Issues ☐Immune Disorder ☐Hypoglycemia ☐Frequent Infection ☐Swollen Glands ☐Low Energy ☐None
Genitourinary	☐Kidney Issues ☐Infertility ☐Bedwetting ☐Prostate Issues ☐ Erectile Dysfunction ☐None
Constitutional	☐Fainting ☐Low LIbido ☐Fatigue ☐Sudden Weight Gain/Loss ☐Weakness ☐None

Personal History (Please provide a complete account of past medical history)

Past and current illnesses or conditions including childhood illnesses:_____

_____

Allergies:_____

_____

Operations and Surgeries:_____

_____

Treatments:_____

_____

Injuries, Broken Bones, Accidents:_____

_____

Family History (Please provide details on known family medical history)

Relative	Age(Living)	Illness	Age at Death	Cause of Death
Mother				
Father				
Sister				
Brother				

Social History (Please provide details about your social history)

Include type, daily/weekly use, and how much consumed or used

Alcohol:_____

Coffee:_____

Tobacco:_____

Pain Relievers:_____

How does your condition affect or limit your abilities in your daily life? Such as: hobbies, work, standing, sitting, driving, sleeping, interactions with others

_____

_____

(for office use)

_____
Patient Name

_____
Patient Number

_____
Doctors Initials

On-Site Chiropractic

Initials	Policy/Acknowledgments
_____	**Payment is expected in full on every visit**. On-Site Chiropractic accepts payment via exact cash, credit/debit card, mobile payment apps and Health Savings Accounts(HSA).
_____	On-Site Chiropractic **does not** accept medical insurance, Medicare, Medicaid, Work Comp, or Personal Injury cases. The patient is responsible for payment of all services.
_____	Upon request, documentation can be provided to the patient for their own personal submission to insurance.
_____	I grant permission to On-Site Chiropractic to contact me to schedule, reschedule, or confirm appointments via: (check all the apply) ☐ **Phone Call** ☐ **Text Message** ☐**Email**
_____	I grant permission to On-Site Chiropractic to contact me with promotional and marketing information related to the practice via: (check all the apply) ☐ **Phone Call** ☐ **Text Message** ☐**Email** ☐ **Postal Service**
_____	I acknowledge that On-Site Chiropractic's Notice of Privacy Practices of Protected Health Information is viewable at www.theonsitechiro.com and details how they use or disclose my personal health information.

(for office use)

_____
Patient Name

_____
Patient Number

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Doctors Initials

On-Site Chiropractic

Patient Signature_____Date_____

Guardian Name _____Relationship_____
(If patient is under the age of 18 years old)

Guardian Signature _____Date_____
(If patient is under the age of 18 years old)