Central Chiropractic Center

Date: ____________________

Patient Information

Name ______________________________________ Sex ☐ M ☐ F Birthdate ____________
last first middle initial

Address ____
street/p.o. box city state zip

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security # ____

Occupation ____________________________ Work Phone: ____________________________

Primary Phone __________________________ Email address: ____________________________

Emergency Contact

Name ______________________________________ Relationship ______________________
last middle initial first

Primary Phone __________________________ Secondary Phone __________________________

Employer Information

Employer ____

Address ____
street/p.o. box city state zip

Phone ____

Spouse/parent Information

Name _________________________________Phone Number:____________________________

Who may we thank for referring you?____

Patient Condition

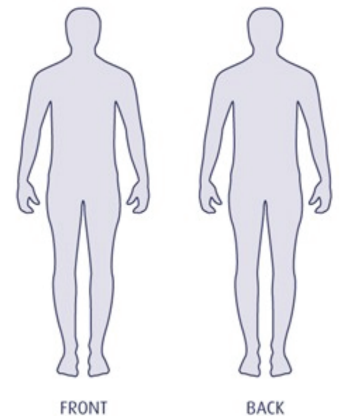
Reason for visit ____

When did your symptoms appear? ____

Is this condition getting progressively worse? _____________________________

Mark an X on the picture where you experience pain, numbness or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain). __________



Type of pain (check all that apply) ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching
☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness
☐ Swelling ☐ Other: ____________________________

How often do you have this pain? ____

Is it constant or does it come and go? _______________________________________

Does it interfere with(check all that apply) ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that area painful to perform(check all that apply) ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down

Central Chiropractic Center

Health History

What treatment have you already received for this condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other ____________

Name and address of other doctor(s) who have treated you for your condition

____

Date of last: Physical Exam ____________ Spinal X-Ray ____________ Blood Test ____________

Spinal Exam ____________ Chest X-Ray ____________ Urine Test ____________

Dental X-Ray ____________ MRI, CT-Scan, Bone Scan ____________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tonsilitis	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tubercolosis	☐ Yes	☐ No
Arthiritis	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Tumors/Growths	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	High Colesterol	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Other		
Cataracts	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Rheumatoid Arthiritis	☐ Yes	☐ No	____________		
Chemical Dependency	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	____________		
Chicken Pox	☐ Yes	☐ No	Measles	☐ Yes	☐ No						
Diabetes	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No						

Exercise	Work Activity	Habits	
☐ None	☐ Sitting	☐ Smoking	Packs per day ____________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks per week ____________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups per day ____________
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason ____________

Are you pregnant? ☐ Yes ☐ No if so, Due date: ____________

Injuries/Surgeries you have had	description	date
Falls	____________	____________
Head injuries	____________	____________
Broken Bones	____________	____________
Dislocations	____________	____________
Surgeries	____________	____________

Medications	Allergies	Vitamins/Herbs/Minerals
____________	____________	____________
____________	____________	____________
____________	____________	____________

CENTRAL CHIROPRACTIC CENTER

INSURANCE INFORMATION

** If this is a personal injury assignment, please skip to "Personal Injury Information"*

Who is responsible for this account? ______________________________

Relationship to Patient ______________________________

Insurance Company ______________________________

Member Number ______________________________ Group ______________________________

Is patient covered by additional insurance? Yes No

Subscriber's Name ______________________________

Birthdate ______________________________ Social Security Number ______________________________

Relationship to Patient ______________________________

Insurance Company ______________________________

Member Number ______________________________ Group ______________________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________________ and assign directly to Dr. Damon Butler all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________________ Date ______________________________

Responsible Party Signature

Relationship to Patient ______________________________

ACCIDENT INFORMATION

Type of accident ______________________________

What was the date of the accident?

____

* PERSONAL INJURY INFORMATION

Attorney Name OR Insurance Adjustor ______________________________

Address ______________________________

Phone ______________________________ Email address: ______________________________

Responsible Insurance Company ______________________________

Claim Number ______________________________

Insured ______________________________

street/p.o. box city state zip

Patient's Auto Insurance Company ______________________________

Primary Phone ______________________________ Email address ______________________________

Policy ______________________________

Will will accept assignment from your attorney for your chiropractic treatment. We will supply your attorney with an evaluation of your condition, progress reports, and final evaluation along with your bill. You are responsible for your bill if you dismiss your attorney or if this office is not paid directly by your attorney or the responsible insurance company.

Patient Signature ______________________________ Date ______________________________

Central Chiropractic Center

Patient Health Information Consent

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 or your Patient Health Information we encourage you to read the HIPPA 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.

Patient's Signature ____ Date ____________________

PARENT/Guardian's Signature ____________________________________ Date ____________________

Informed Consent for Chiropractic Care

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illness or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Central Chiropractic Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient's Signature ____ Date ____________________

PARENT/Guardian's Signature ____________________________________ Date ____________________

CENTRAL CHIROPRACTIC CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Central Chiropractic Center to use and/or disclose all medical records and bills to the entities below:

REQUESTOR NAME: ____
____
____
____

PATIENT'S NAME______________________________________ D.O.A.: ________________________

PATIENT ADDRESS ____

DATE OF BIRTH: ______________________________________ SS#: __________________________

This authorization shall expire upon this expiration date:____________________________________.
If I fail to specify an expiration date, this authorization will expire one (1) year from the date on which it was signed.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to Central Chiropractic Center. I understand that the revocation will not apply to information that has already been released to this authorization. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may refuse to sign this authorization and it is strictly voluntary.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

I have read the above and authorize the disclosure of the protected health information as stated.

A photocopy of this authorization is to be accepted and given the same effect as the original.

____ ________________________
Signature of Patient/Legal Representative Date

If signed by legal representative, relationship to patient: ____________________________________

____ ________________________
Signature of Witness Date

CENTRAL CHIROPRACTIC CENTER

ACCIDENT/INJURY REPORT FORM

Name: ______________________________ Today's Date: ______________

Date of Accident: ______________________ Time of Accident: ______________________

Weather condition at the time of Accident: [ ] clear [ ] raining [ ] foggy [ ] other

Were you the: [ ] driver [ ] front passenger [ ] rear passenger

Were you wearing a seatbelt? [ ] yes [ ] no Braced for impact? [ ] yes [ ] no

What direction was the impact from? [ ]front [ ] rear [ ]right side [ ] left side

Did you go to the hospital right away? [ ] yes [ ] no Later? [ ] yes [ ] no

If so, which hospital? ____

Were you x-rayed there? [ ] yes [ ] no

What treatment did you receive? [ ] medication [ ] other ______________________

Have you seen other doctors as a result of this accident? [ ] yes [ ] no

If yes, please list: ____

Have you had any previous permenant injuries as a result of prior accidents, injuries or illness? [ ] no [ ] yes

If yes, please describe when and what: ____

____

____

Part of the body injured

[ ] Abdoman	Ankle	[ ] right	[ ] left
[ ] Back	Arm	[ ] right	[ ] left
[ ] Chest	Ear	[ ] right	[ ] left
[ ] Face	Elbow	[ ] right	[ ] left
[ ] Fingers	Eye	[ ] right	[ ] left
[ ] Head	Foot	[ ] right	[ ] left
[ ] Mouth	Hand	[ ] right	[ ] left
[ ] Nose	Knee	[ ] right	[ ] left
[ ] Scalp	Leg	[ ] right	[ ] left
[ ] Teeth	Wrist	[ ] right	[ ] left

[ ] Other (specify) ____