New Patient Health History Form

All information is strictly CONFIDENTIAL

PATIENT INFORMATION

Patient Name _____ Birth Date _____

Address _____
Address City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Phone Preference (circle): Home Cell Work None Email _____

Do you mind receiving email notifications from us? ❑ Y ❑ N Your email will NOT be shared with any 3rd parties.

Sex ❑ M ❑ F Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed Minor ❑ Y

Occupation _____ Employer _____

EMERGENCY CONTACT: Name _____ Relationship _____

Home Phone _____ Cell Phone _____ Work Phone _____

Phone Preference (circle): Home Cell Work None

INSURANCE INFORMATION

Insurance Company _____ Phone _____

Identification # _____ Group # _____

Address _____

Subscriber's Name _____ Subscriber's Birth Date _____

FINANCIAL POLICY

1) I realize that Crawford Chiropractic requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the doctor or office manager. (This office may make payment plan arrangements on an individual basis).
2) I realize that my insurance, worker's compensation, and liability/personal injury company or attorney may not pay the entire bill. I realize I am responsible for the entire bill should my insurance company or attorney not pay any of the anticipated charges for any reason.
3) I realize that Crawford Chiropractic is not a mediator between me and my insurance company. If coverage problems arise, I will be expected to assist directly in dealing with my insurance company, adjuster, or agent.
4) I realize that if my insurance has not paid Crawford Chiropractic within 60 days of the date of service and no financial arrangements have been made, I will be responsible for the unpaid amount. I realize that Crawford chiropractic may add interest to my account at 1% per month.
5) I grant Crawford Chiropractic permission to disclose my health care information to any insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits.
6) I agree to pay all reasonable costs that Crawford Chiropractic may incur to collect any debt owed. This includes, unless prohibited by law, all reasonable attorney's fees, filing fees, court costs, collection agency costs, service fees, and other related collection costs or contingencies. I understand that if any unpaid balances are turned over to a collection agency that a fee ranging from 35% to 50% will be added to the total balance due.

I have read the office financial policy described above. I assign directly to Dr. Brian B. Crawford / Crawford Chiropractic, all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

Patient's Signature _____ Date _____

Signature of Parent of Guardian _____ Date _____

Name of parent or guardian where you want bill sent _____

Address _____
Address City State Zip

Relationship to patient _____ Phone _____

PATIENT CONDITION

Reason for visit _____

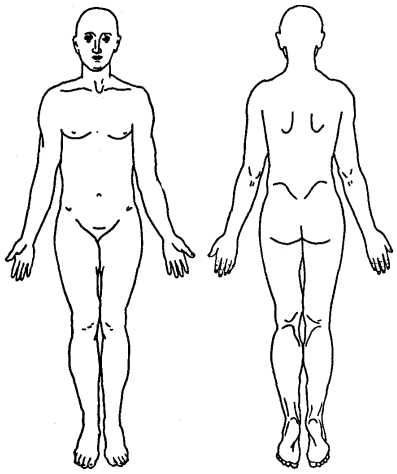
When did symptoms first appear? _____

Is this condition due to an accident? ❑ Yes ❑ No Date _____

Type of accident: ❑ Automobile ❑ Work-related ❑ Home ❑ Other

Is this condition getting progressively worse? ❑ Yes ❑ No

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Type of pain: ❑ Dull ❑ Throbbing ❑ Aching ❑ Sharp ❑ Shooting
❑ Burning ❑ Cramping ❑ Spasms ❑ Stiffness ❑ Numbness
❑ Tingling ❑ Swelling ❑ Other _____

Rate the pain on a 0 (no pain) to 10 (unbearable) scale. _____

How often do you have the pain? ❑ 0-25% of time ❑ 25-50% ❑ 50-75% ❑ 75-100%

What treatment have you already received for this condition? ❑ Medications ❑ Surgery
❑ Physical Therapy ❑ Chiropractic ❑ None ❑ Other _____

Doctors who have treated you for your condition _____

HEALTH HISTORY

Are you currently experiencing or recently experienced any of the following?

❑ Persistent pain at night ❑ Constant pain anywhere in the body ❑ Unexplained weight loss ❑ Loss of appetite
❑ Easily bruised ❑ Unusual lumps or growths ❑ Unwarranted fatigue ❑ Chills, fever, or night sweats
❑ Pregnancy ❑ Loss of bowel or bladder function ❑ Recent cancer diagnosis ❑ Recent cancer treatment

Cardiovascular

❑ Shortness of breath ❑ Pain or feeling of heaviness in chest ❑ Heart palpitations ❑ High Blood Pressure
❑ Swelling of legs ❑ Pain in legs/calves while walking ❑ Discolored or painful feet ❑ History of heart attack

Neurological

❑ History of stroke ❑ Headaches with no history of injury ❑ History of migraines ❑ Problems with swallowing
❑ Changes in speech ❑ Balance or coordination problems ❑ Recent changes in vision ❑ Seizures
❑ Fainting spells ❑ Dizziness or vertigo ❑ Black outs ❑ Tremors
❑ Recent hearing loss ❑ Ringing in the ears (tinnitus) ❑ Numbness ❑ Sudden weakness

Musculoskeletal

❑ Arthritis in neck ❑ Bulging/herniated discs in neck ❑ Numbness/tingling in arms ❑ Weakness in arms
❑ Arthritis in back ❑ Bulging/herniated discs in back ❑ Numbness/tingling in legs ❑ Weakness in legs
❑ Joint pain ❑ Joint stiffness ❑ Osteoporosis ❑ Artificial joints

Illnesses or Conditions unrelated to current complaints _____

_____

SURGICAL HISTORY

_____

_____

MEDICATIONS

_____

_____

HABITS

❑ Smoker Packs/Day _____ ❑ Alcohol Drinks/Week _____ ❑ Sugary Drinks/Sodas Drinks/Week _____
❑ High Carb Diet ❑ High Stress Levels Reason _____
❑ Cardio per week _____ ❑ Resistance/Weights per week _____ ❑ Walking per week _____ ❑ Other per week _____

In addition to your current complaint, is there anything else you would like to discuss? For example:

❑ Neck pain ❑ Back Pain ❑ Headaches ❑ Arm/hand pain or tingling ❑ Leg/foot pain or tingling
❑ Massage therapy ❑ Weight loss ❑ Type II diabetes ❑ Family member's health ❑ Allergies
❑ Other _____