

BULLITT CHIROPRACTIC, P.A.

PATIENT INFORMATION

NOTE: PLEASE COMPLETE THIS FORM WITH YOUR SIGNATURE AT THE BOTTOM OF THE PAGE

Patient's Name: _____ Nickname: _____

Social Security #: _____ E-mail Address: _____

Address: _____ Home Phone: (_____) _____

City _____ State _____ Zip _____ Cell Phone: (_____) _____

Birth Date: _____ Sex: M F Marital Status: M S W D Work Phone: (_____) _____

Employer _____ Occupation: _____

Spouses Name: _____ Spouses Date of Birth: _____

Name and Age of Children: _____

Name of your physician: _____ Would you like a report sent to him/her? yes no

Name and number of Nearest Relative not living with you _____ Phone #: _____

Who or What Referred you to the office of BULLITT CHIROPRACTIC? _____

INSURANCE INFORMATION*

**Please complete this section in full if you are covered by insurance or are entitled to receive benefit payments.*

This information will assist us in helping you obtain the benefits to which you may be entitled.

Name of Insured: _____ Insured's Birth Date: _____

Insured's Employer: _____ Address: _____

Name of Insurance Company _____

Address _____

Type: Group Private Workman's Comp Automobile

Policy# _____ Group# _____ Membership# _____

PATIENT CERTIFICATION AND SIGNATURE.

I certify that the above information is true and correct. I hereby authorize the release of any information required to secure payment for services rendered. I also authorize and direct that any insurance or medical coverage benefit payments to which I may be entitled shall be paid directly to **Bullitt Chiropractic, P.A.**

I understand and agree that I am financially responsible for and will promptly pay any non-covered services including, but not limited to, deductible and copay.

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 of 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** _____

BULLITT CHIROPRACTIC, P.A.
PATIENT CONDITION INFORMATION

Name: _____

Main complaint and symptoms: _____

Describe the pain: Sharp Dull Tightness Numbness Tingling Aching Burning Stabbing

Does the pain radiate into your arms or legs? yes no Which? _____

How frequent is the condition? Constant Intermittent Daily Night only

How long does it last? All Day Few Hours Minutes

When did you first notice this problem? _____

Has your condition improved gotten worse or stayed the same since its onset?

Was your condition caused or aggravated by and accident? yes no.

If your above answer is yes, please check the type of accident? Auto On Job Other

Describe the Accident _____

What makes your condition worse? Sitting Standing Lying Bending Lifting Twisting

Other _____

Does anything make it feel better? _____

Have you had any previous treatment for this or similar conditions? yes no.

When? _____ Treated how long? _____ Who treated you? _____

Results? _____

Have you been under previous chiropractic care? yes no Who? _____

List and describe the nature of any Surgery, Trauma, Injury, or Medications: _____

Women: Is there any possibility that your pregnant? yes no Date of Last Menstrual Period: _____

INFORMED CONSENT

Informed consent is more than just a signed document. The following categories will be or have been discussed.

- What's wrong? or your diagnosis.
- What tests will be ordered; the reason for them; and results expected to achieve.
- Whether or not Chiropractic can be helpful in this case.
- Alternative treatments and your options.
- A treatment plan outlined for your case with expected time frame for results.
- Cost of this Treatment.

These categories have been discussed with me in my report of findings; and I am authorizing the doctor to treat my conditions within the parameters outlined, to the best of his ability.

PATIENT'S SIGNATURE _____ **DATE:** _____

Symptoms that can be related to Spinal Nerves

Please mark area of pain on diagram.

Past Present No

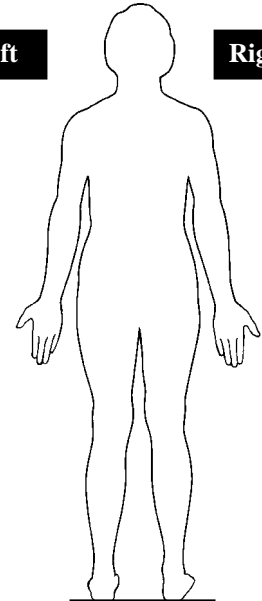
- Scalp Disorders
- Head Pain or Headaches
- Neck Pain
- Shoulder Pain or Stiffness
- Arm Pain
- Tennis Elbow
- Loss of Arm Power
- Loss of Grip
- Tingling, Numbness, or Pain of Hand
- Mid Back Pain
- Mid Back Tension
- Pain in Ribs

Past Present No

- Low Back Pain
- Low Back Weakness
- Low Back Stiffness
- Hip Pain or Stiffness
- Buttock Pain
- Leg Cramps
- Tingling, Numbness, or Pain of Leg
- Knee Trouble
- Foot Trouble
- Tingling, Numbness, or Pain of Foot

Left

Right



Back

No Symptoms

Extreme Symptoms

_____ Please place an "X" on the line above to indicate your level of PAIN.

Family History

	Father	Mother	Siblings	Grandparents	Children
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Members Still Alive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Hereditary Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How many children do you have? _____

What are their current ages? _____

Personal Habits

Type	Amount	Per *
Exercise	_____	_____
Dairy Products	_____	_____
Soda Pop	_____	_____
Coffee/Tea	_____	_____
Alcoholic Beverages	_____	_____
Tobacco (any type)	_____	_____
Drugs (any type)	_____	_____
Vitamins	_____	_____

* Please write Day, Week, or Month as applicable.

Occupation

What is your trade? _____

Does your job require you to:

- Sit Stand Bend Walk Lift

How much? _____

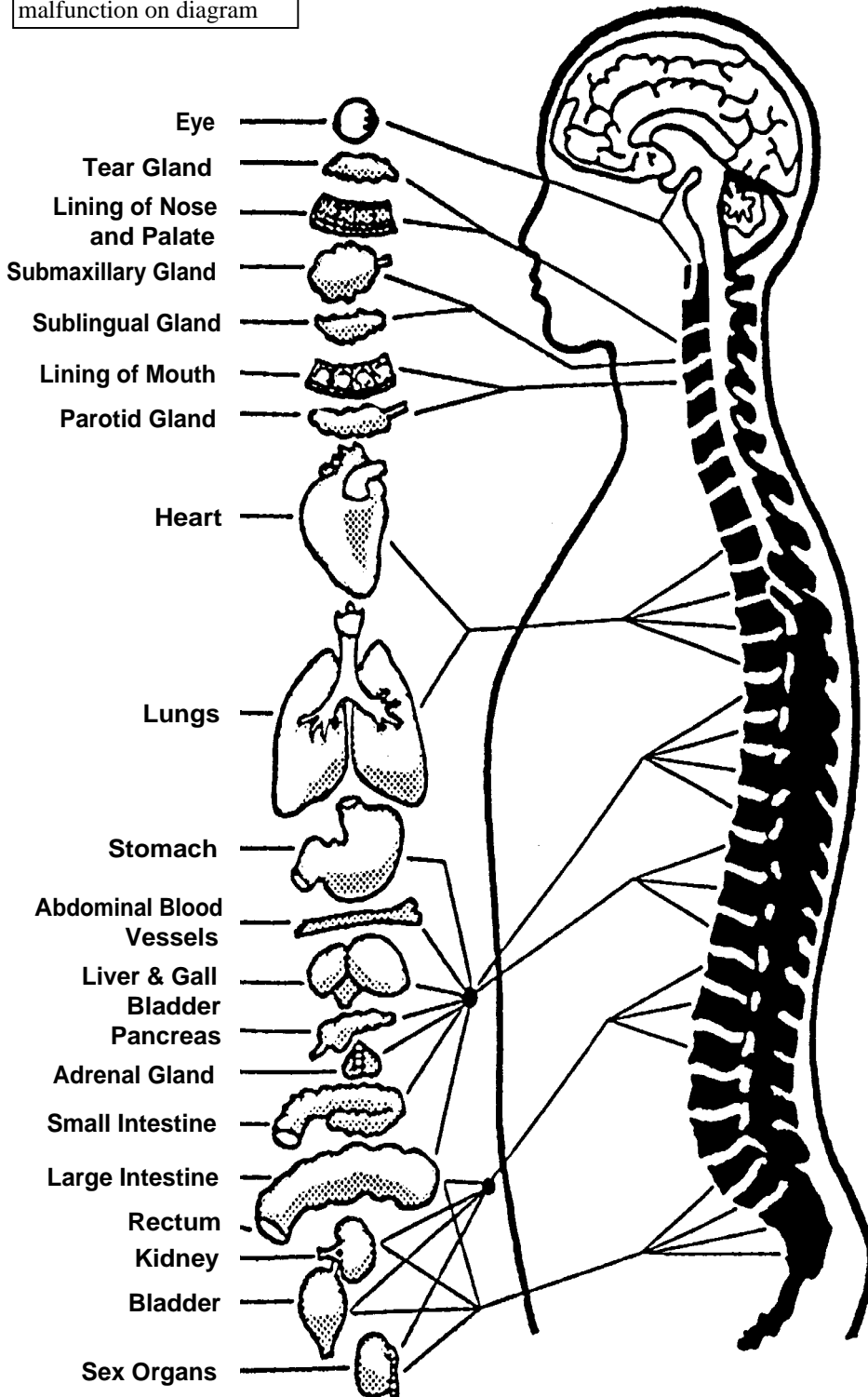
Dr.'s Notes: _____

Bullitt Chiropractic, P.A.

Health Questionnaire

Please circle area of pain or malfunction on diagram

Are you now or have you suffered from any of the following...
Check Appropriate Box.



Past
Present
No

- Eye disorders
- Loss of Taste
- Headaches
- Nervousness
- Trouble Sleeping
- Dizziness
- Loss of Smell
- Sinus Trouble
- Ear Disorders
- Frequent Sore Throats
- Asthma
- Hay Fever/Allergies
- Persistent Coughs
- Stomach Problems
- Rheumatic Fever
- Tuberculosis
- Heart Disease
- High Blood Pressure
- Diabetes
- Poor Digestion
- Nausea
- Vomiting
- Constipation
- Diarrhea
- Abdominal Pains
- Hemorrhoids
- Urinary Disorders
- Bed Wetting
- Menstrual Disorders
- Sex Problems
- Tension
- Irritability
- Fatigue

Symptoms related to the Autonomic Nervous System

Chiropractic deals with the relationship between your spine and nervous system.

The Nervous System's function is to control and coordinate all the other organs and structures. Pinched or irritated nerves may interfere with the function and thus cause a wide variety of symptoms.

Patient's Name _____

Date _____