UNIVERSITY CHIROPRACTIC AND WELLNESS

PERSONAL HISTORY

Date

Name Social Security No.

Address

City State ZIP

Best Phone Number to Reach You Text Reminder? Yes No

Email Address

Birthday (M/D/Y) Age Sex Height/Weight

Name of Employer Type of Work

Name of Insurance Company Marital Status

Name of Spouse Spouse Employer

Emergency Contact Name Emergency Contact Ph.#

Who is Responsible for Your Bill?

Insurance Auto Insurance Workers' Compensation Self Other

Past Health History

Please Check and/or Describe the Following *(If Applicable)*

Operations (Spinal or Joint)

Accidents or Falls

Habits:

Sleep *(hours)* Exercise *(Days per week)* Caffeine *(Days per week)*

Alcohol *(Days per week)* Tobacco *(Days per week)*

Are You Pregnant? Yes No **If Yes**, How Far Along Are You?

Do You Understand that Chiropractic is a **Drugless**, **Non-Surgical** Form of Health Care?

Yes No

Purpose of this Appointment

Are You Taking Medication for **this** Condition (*ex. Pain Killers*)? Yes No

Have You Seen Another Doctor for this Condition? Yes No

If Yes, Who? Results

When did this Condition Begin? Is this an Ongoing Problem? Yes No

Is the Condition... Job-Related From an Auto Accident

Date of Accident (*If Applicable*)

Please Check All of the Following Symptoms You Have Now

- Headaches
- Neck pain and/or stiffness
- Fainting/dizziness
- Pins/needles in arms/hands/fingers
- Numbness in arms/hands/fingers
- Pain in arms/hands fingers
- Back pain
- Pins/needles in legs/feet/toes
- Numbness in legs/feet/toes
- Pain in legs/feet/toes
- Chest pain/previous heart attack
- High blood pressure
- Pain between shoulder blades

Please Check All of the Following Conditions You Have Now

- [ ] Asthma
- [ ] Frequent colds
- [ ] Sinus trouble
- [ ] Loss of sleep
- [ ] Weight loss
- [ ] Difficulty breathing
- [ ] Stomach pain
- [ ] Joint swelling
- [ ] Constipation or diarrhea
- [ ] Faulty posture
- [ ] Spinal curvature
- [ ] Epilepsy
- [ ] Cancer

Please Check All of the Following Symptoms You Have Had Previously

- [ ] Headaches
- [ ] Neck pain and/or stiffness
- [ ] Fainting/dizziness
- [ ] Pins/needles in arms/hands/fingers
- [ ] Numbness in arms/hands/fingers
- [ ] Pain in arms/hands fingers
- [ ] Back pain
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PAIN QUESTIONNAIRE

What is Your **Current** Pain Level? /10

What is Your Pain Level at Its **Best**? /10

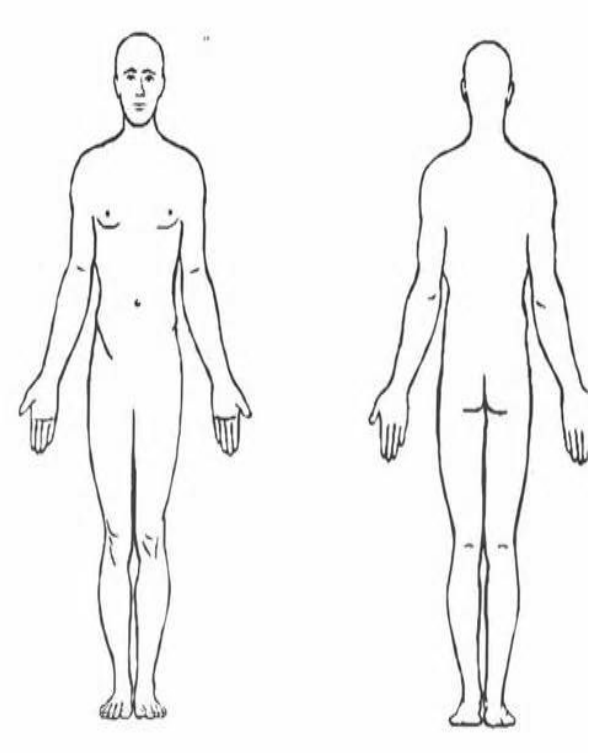
What is Your Pain Level at Its **Worst**? /10

How Much of the Day Do You Have Pain? 25% 50% 75% 100%

How Many Days of the Week Do You Have Pain?

What Types of Activities **Aggravate** Your Symptom(s)?

What Types of Activities **Improve** Your Symptom(s)?



Any Additional Comments

Signature Date

UNIVERSITY CHIROPRACTIC AND WELLNESS

Date

To Whom It May Concern:

I, , with the birthday hereby request that the following facility release all of my medical records, X-rays, test reports, etc.:

Name of Facility

Street Adress of Facility

City of Facility **State of Facility** **ZIP Code**

These Released Records Can Be Faxed to:
University Chiropractic and Wellness
Attn: Records Department
1-855-873-5021

OR Mailed to:
University Chiropractic and Wellness
2108 State Route 59, Unit A
Kent, OH 44240

Patient's Signature **Date**

Staff Signature **Date**

UNIVERSITY CHIROPRACTIC AND WELLNESS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice is effective as of ____ / ____ / ____

HIPPA

I have read the Notice of Privacy Practices and understand my rights contained in the notice.
By way of my signature, I provide University Chiropractic and Wellness with my authorization and consent to use and disclose my protected health care information with the purpose of treatment, payment, and health care operations as described in the Notice of Privacy Practices.

VIDEO SURVEILLANCE

The waiting room of our office is equipped with one video camera for safety purposes. We store these recordings in electronic format for 7-10 days but we do not make or keep videotapes of these recordings. The waiting room is the only room with video surveillance.
By way of my signature, I acknowledge the use of video surveillance.

Patient's Name		**Date**	
Patient's Signature		**Date**	
Authorized Signature of Witness for Facility		**Date**	

UNIVERSITY CHIROPRACTIC AND WELLNESS

University Chiropractic and Wellness offers a “free first visit” that includes the following:

- Consultation with the doctor
- Exam with the doctor consisting of palpatory and range of motion testing
- Fifteen minute massage with a licensed massage therapist

If the doctor feels that you could benefit from chiropractic treatment, most insurance companies cover further exams, X-rays, and treatment. We will need to make a copy of your insurance card so that our insurance specialist can verify your chiropractic coverage.

By signing this, I understand the “free first visit” offer.

Patient’s Name **Date**

Patient’s Signature

*****Due to federal guidelines, Medicare/Medicaid/Workman’s Compensation restrictions, this free offer is not available to these participants.*****