Riverside
CHIROPRACTIC CENTER

Today's Date______________________

## PATIENT INFORMATION

Name ____________________________________________ Age __________ Date of Birth ____________________

Home Address __________________________________ City __________________ State ______ Zip ___________

Home phone (____) ___________________________ Cell Phone (____) _______________________________

E-mail address________________________________________________________________________________

Occupation _____________________________ Employer/School_________________________________________

Marital Status ❑ S ❑ M ❑ D ❑ W Spouse/Partner ____________________________________________

Names and Ages of Children_______________________________________________________________________

Whom may we thank for referring you to our office? _____________________________________________

Do you have insurance? ______No __________Yes - If yes, who? _____________________________________

In case of emergency, contact? Name_______________________________ Phone (____)_________________

PCP Name/Address: ____________________________________________ Phone (____)__________________

## PATIENT CONDITION

Reason for today's visit? _______________________________________________________________________

When did symptoms start? _______________________________________________________________________

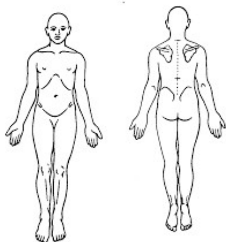
Is this condition getting worse? _______No _________Yes – If Yes, how? ______________________________

Have you had this problem before? ____ No ___Yes - If Yes, when? ____________________________________

## PAIN SUMMARY

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

__1 __2 __3 __4 __5 __6 __7 __8 __9 __10



Type of Pain ___Sharp ___Dull ___Throbbing ___Numbness ___Aching

___Shooting ___Burning ___Tingling ____Cramps ___Stiffness ___Swelling

___Other ________________________________

Pain is better in the: _______morning _______evening Pain is worse in the: _______morning _______evening

What makes your condition better? ______________________________________________________________

What makes your condition worse? ______________________________________________________________

Do you smoke? ___ No ___ Yes Do you consume alcohol? ___ No _____ Yes

## THIRD PARTY RESPONSIBILITY

Is this an Auto Accident? ☐ Yes ☐ No Work-Related Injury? ❑ Yes ❑ No

If **yes**, please provide us with the following information:

Have you been treated elsewhere? ❑ Yes ❑ No

If **yes**, where? ❑ Emergency Room ❑ Primary Care ❑ Other ______________________________

What services were provided? ❑ MRI ❑X-Rays ❑ Medication ❑ Therapy ❑ Other ________________

## MEDICAL HISTORY

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

| | You | Mom | Dad | Sibling | | You | Mom | Dad | Sibling |
|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | | | | | Miscarriage | | | | |
| Alcoholism | | | | | Mononucleosis | | | | |
| Allergy Shots | | | | | Multiple Sclerosis | | | | |
| Anemia | | | | | Osteoporosis | | | | |
| Anorexia | | | | | Pacemaker | | | | |
| Asthma | | | | | Parkinson's Disease | | | | |
| Bleeding Disorder | | | | | Pinched Nerve | | | | |
| Breast Lump | | | | | Pneumonia | | | | |
| Bronchitis | | | | | Prostate Problem | | | | |
| Bulimia | | | | | Psychiatric Care | | | | |
| Cancer | | | | | Rheumatoid Arthritis | | | | |
| Cataracts | | | | | Scarlet Fever | | | | |
| Chem. Dependency | | | | | Stroke | | | | |
| Chicken Pox | | | | | Suicide Attempt | | | | |
| Covid-19 | | | | | Thyroid Problems | | | | |
| Diabetes | | | | | Tuberculosis | | | | |
| Emphysema | | | | | Tumors, Growths | | | | |
| Epilepsy | | | | | Ulcers | | | | |
| Fractures | | | | | Whooping Cough | | | | |
| Glaucoma | | | | | | | | | |
| Goiter | | | | | | | | | |
| Gout | | | | | Other: | | | | |
| Hearing Problems | | | | | ______________________________ | | | | |
| Heart Disease | | | | | | | | | |
| Hepatitis | | | | | List All Medications, Dose & Frequency: | | | | |
| Hernia | | | | | | | | | |
| Herniated Disc | | | | | ______________________________ | | | | |
| High Blood Pressure | | | | | ______________________________ | | | | |
| High Cholesterol | | | | | ______________________________ | | | | |
| Kidney Disease | | | | | ______________________________ | | | | |
| Liver Disease | | | | | ______________________________ | | | | |
| Measles | | | | | Are your vaccines up to date? ☐ Yes ☐ No | | | | |
| Migraine Headache | | | | | If No, what is missing? ______________________________ | | | | |

***PLEASE READ, INITIAL and SIGN***

## HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT

I have been informed that a copy of Riverside Chiropractic Center's "Notice of Privacy Practices for Protected Health Information (HIPAA)" policy poster is available for my review in the office.

Name: (Printed) ___________________________________________ Date of Birth: ________________________________

Signature:_________________________________________________________________ Date: ______________________

## AUTHORIZATION, ASSIGNMENT AND CONSENT TO TREAT

Please Initial Below

______________ I hereby authorize RIVERSIDE CHIROPRACTIC CENTER to bill the insurance company for services rendered on my behalf. The billing of such services is a privilege and not a guarantee of coverage. I further authorize the physician and/or suppliers to release any information required to process my insurance claims.

______________ I authorize direct payment to you any sum I now or hereafter owe, by my attorney out of the proceeds of any settlement of my case, and/or by insurance company obligated to make payment to me or you based in whole or part upon the charges made for the services.

______________ I understand that whatever amounts you do not collect from the insurance company and/or my attorney, whether it all or part of what is due, I personally owe and agree to pay to Riverside Chiropractic Center.

______________ I authorize the release of my medical records to my family practitioner or other physician ______________, to my health insurance company, or third party payers including insurance, workerman's compensation, attorney, auto insurance, etc. if requested.

______________ I authorize Riverside Chiropractic Center to send information to my house concering birthdays or newsletters, to leave messages on my home/cell/work voicemails, and send emails and text messages.

I hereby authorize the doctor(s) or RIVERSIDE CHIROPRACTIC CENTER and whomever they designate as their assistant or authorized representative to administer chiropractic care, acupuncture, or muscle work as they deem necessary. We invite you to discuss openly treatment, services, and charges rendered at this office, so that there is mutual agreement and clarity.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge, and understand it's my responsibility to inform this office of any change in my medical or billing/financial status.

Name: (Printed) ____________________________________________Date: ______________________

Signature:_____________________________________________________________________________

Signature of Parent (for minor):________________________________ Date: ______________________