Patient Health History

Today's Date / / **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____ **Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Continued ...

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____
Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1) _____		5) _____	
2) _____		6) _____	
3) _____		7) _____	
4) _____		8) _____	

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ 3) _____

2) _____ 4) _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

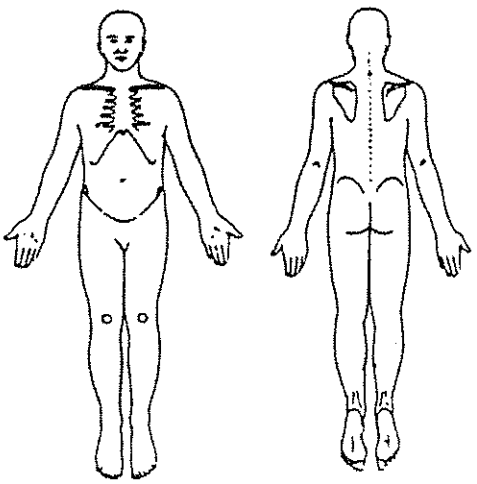
Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____

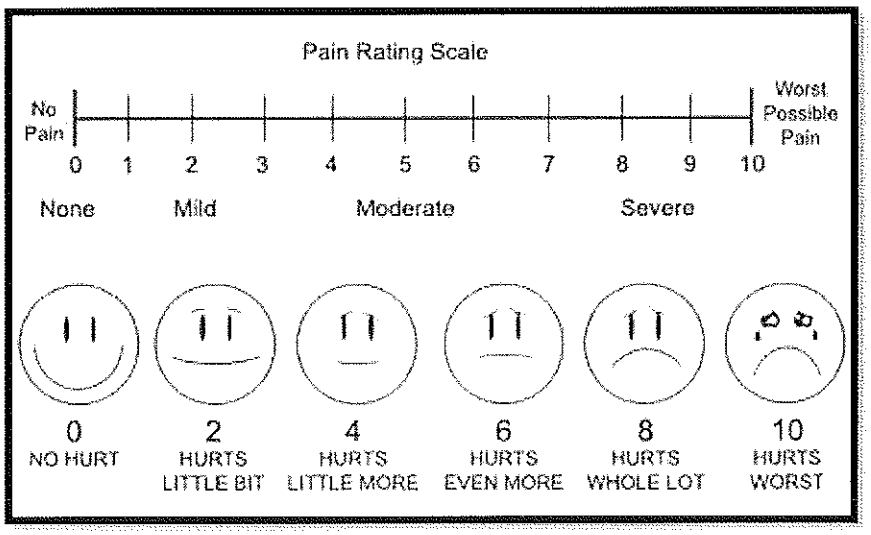
WELCOME TO
OUR OFFICE

Atlas Family Chiropractic · 1255 Boyson Loop Hiawatha, IA 52233·
Phone: 319-393-7744 · Fax: 319-393-1035

PATIENT INFORMATION	**DATE** / /
Employer:	**INSURANCE INFORMATION**
Employer Address:	Please present your insurance cards and photo ID.
City/State/Zip:	Policy Holder Name:
Occupation:	Birthdate: / / Self ☐Spouse ☐Child/Dep.
Work Phone:	
EMERGENCY CONTACT	**REFERRAL** How did you find our office?
Relation and Name:_____ Contact Phone:	Phonebook ☐Insurance ☐Internet ☐Location ☐Mailing ☐Sign ☐Patient, their name? _____
RESPONSIBLE PARTY- If you are younger than 18.	**ACCIDENT INFORMATION**
Name:	Is condition result of an accident? YES NO
Relation: Phone:	If Yes (Work, Auto) please ask for additional forms.
PATIENT HISTORY	**PAST HISTORY**
Where is your pain?	Have you had any fractured bones? ☐YES ☐NO
	Where? When?
Mark any symptoms that you currently have:	Have you ever been hospitalized? ☐YES☐NO
☐Headaches ☐Nausea ☐Difficulty walking	Are you pregnant? ☐YES ☐NO
☐Neck pain ☐Upper back pain ☐ Joint pain	Do you have abnormal menstrual problems? ☐YES ☐NO
☐Jaw pain ☐Low back pain ☐ Stiffness	List ALL past surgeries or procedures and approx. year:
☐Shoulder pain ☐Leg pain ☐ Muscle spasms	
FAMILY HISTORY- Parents and siblings only.	Mark any diseases you have had below.
☐Cancer ☐Clotting Disorder ☐Dementia	☐Anemia ☐Heart Disease ☐Arthritis ☐Pneumonia
☐Diabetes ☐Gastrointestinal ☐Heart Disease	☐Measles ☐Mumps ☐Epilepsy ☐Influenza
☐High Cholesterol ☐Hypertension ☐Kidney Disease	☐Mental disorder ☐Diabetes ☐Rheumatic fever
☐Lung Disease ☐Osteoporosis ☐Psychological Disorder	☐Eczema ☐Whooping Cough ☐Cancer ☐Alcoholism
☐Septicemia ☐Stroke ☐Sudden Infant Death Syndrome	☐Tuberculosis ☐AIDS/HIV ☐Venereal Disease
Description:	
	MEDICAL DOCTOR NAME:

Indicate areas of pain on the diagram below





Please do not hesitate to ask about fees. We will be glad to file insurance claims at no charge.
You are responsible for any balance not paid by your insurance company.

IF NO INSURANCE: Payment is due when treatment is given.

INSURANCE: Deductibles, co-payments, and non-covered services are expected to be paid at the time of service or at the end of each month. It is your responsibility to provide us with the proper insurance card. If you discontinue treatment, any charges are immediately due and payable.

TREATMENT PERMISSION: I understand that I am responsible for all charges whether or not paid by any third party. I agree that all charges are payable, collectible, and prosecutable in Linn County. If I do not make payment on my account after it is 90 days past due, the account may be turned over for collections and I may be charged the cost of collections. All portions of any bill sent to me by Atlas Family Chiropractic shall be assumed valid unless disputed in writing within thirty (30) days of receiving the bill.

ASSIGNMENT OF RIGHT TO PAYMENT/LIEN AGAINST BENEFITS: I authorize Atlas Family Chiropractic to file my insurance claim. I assign them my right to receive any and all payments or recoveries from any insurance company, attorney, or third party for professional services rendered by Atlas Family Chiropractic. I convey a lien against any funds and authorize and direct any third party to withhold sums from any benefits, judgments, verdict, settlements or recoveries, and to adequately protect and to make payment for these services directly to Atlas Family Chiropractic pursuant to this assignment and lien.

LIMITED RELEASE OF MEDICAL INFORMATION: I authorize Atlas Family Chiropractic to make inquiries and to release any pertinent information to any insurance company, adjuster, or attorney to facilitate collection under these assignments.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received a copy of the Notice of Privacy Practices.

AUTHORIZATION: By signing below I am agreeing to the terms listed above as well as giving my permission and consent for treatment given by Atlas Family Chiropractic.

PRINT NAME:_____ **SIGNATURE:**_____ **Date**_____