Welcome

Thank you for choosing Comfort Chiropractic for your chiropractic needs.
If you have any questions, please ask for assistance. We will be happy to help!

Name: ____
First Middle Last

Preferred name: ________________ Date of Birth: ________________ Age: ________

Address: ____ Apt #: ________

City: ________________________ State: ____________ Zip: ____________

Spouse: ________________________ Children: ________________________

Occupation: ________________________ Employer: ________________________

Insurance Company: ________________________ Primary Insured: ________________________

Who referred you to our office? ____

By checking the line(s) I authorize being contacted for reminders, greetings, and promotions by the practice:

_____ Text Message _____ Email _____ Telephone _____ Voicemail _____ Mail _____Facebook

Home Phone: ________________________ Cell Phone: ________________________

Work Phone: ________________________ Email: ________________________

Contact Preference: _____ Text Message _____ Email _____ Home Ph _____Work Ph _____ Mail

Please list your complaints below

1) ________________________ For How Long? ____________
2) ________________________ For How Long? ____________
3) ________________________ For How Long? ____________
4) ________________________ For How Long? ____________

Check any other symptoms that apply:

- ❑ Headache
- ❑ Neck pain
- ❑ Upper back pain
- ❑ Middle back pain
- ❑ Lower back pain
- ❑ Buttock pain
- ❑ Pain in the arms/hand/fingers
- ❑ Pain in the legs/feet/toes
- ❑ Numbness in the arms/hand
- ❑ Numbness in the legs/feet
- ❑ Pain in the shoulder(s)
- ❑ Pain in the elbow/wrist
- ❑ Pain in the knee
- ❑ Sensitive to light
- ❑ Sleeping problems
- ❑ Loss of memory
- ❑ Chest pain
- ❑ Loss of balance
- ❑ Nervousness
- ❑ Fatigue
- ❑ Irritability
- ❑ Dizziness

Other ____

On the human figure to the right, please circle your areas of pain then grade your pain using the scale below.

1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

HAVE YOU EVER

Been knocked unconscious?	Yes ❑	No ❑
Had a fracture or broken bone?	Yes ❑	No ❑
Been in a car accident?	Yes ❑	No ❑
Been treated for a spine or back problem?	Yes ❑	No ❑
Been hospitalized for surgery or injuries?	Yes ❑	No ❑

If YES to any of the above, please describe below.

____

____

____

Any family history of cancer, heart disease, diabetes, back pain, or headaches?

____

____

Name and relationship of people to whom you authorize the Practice to release Personal Health Information:

____________________ ____________________

____________________ ____________________

OFFICE POLICIES

1. In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. However, we do not participate in all plans. Please understand that health and accident insurance policies are an arrangement between the insurance carrier and yourself, if your carrier refuses to pay for services rendered then it is your responsibility to pay those charges. Outstanding balances due and payable by the 10th of the month. Finance Charge of 1½ % per month which is an annual percentage rate of 18% (or minimum $10.00 per month) will be charged on all past due accounts over 30 days. If the account is placed for collection, additional charge equal to the cost of collection including agency and attorney fees and court costs incurred and permitted by laws governing these transactions will be added to the amount due.
2. **I hereby instruct and authorize my insurance company to pay by check made out and mailed directly to: Comfort Chiropractic, 750 SE Indian St., Stuart, FL 34997.**
3. I understand that no guarantees have been made concerning my recovery as every individual responds to chiropractic differently. I hereby authorize Comfort Chiropractic and whomever they may designate as an assistant to administer therapies and take x-rays if needed. I also state, to my knowledge, I am not pregnant at this time for the purpose of x-rays if needed.
4. I authorize Comfort Chiropractic to release any or all of my medical records as deemed necessary to other health care providers. I also authorize release of records to my insurance company as requested to facilitate payment to Comfort Chiropractic. I understand this office will take all necessary precautions to insure my privacy. I have given a copy of the HIPAA regulations for my review.
5. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

I have read and understand the office policy stated above and agree to accept responsibility as described.

____ By checking this line, I authorize the doctor to personally discuss with me products that may benefit my health or condition.

Signature: ____________________________ **Date:** ____________

Name of Parent or Legal Representative (if applicable): ____________________

Patient Name: ____ **Date:** ____________________

Due to changes in the healthcare industry, we are asked to obtain this information on patients treated in our office.

General Information:

Language: _____English _____Spanish _____Indian _____Japanese _____Chinese

_____Korean _____French _____German _____Russian _____Other

Race: ____White _____Black or African American _____Asian _____ Hispanic or Latino

____ Native Hawaiian/Other Pacific Islander _____American Indian/ Alaska Native

_____ Decline to Answer

Ethnicity: _____ Hispanic or Latino _____Not Hispanic or Latino _____ Decline to Answer

Patient History

Are you seeing anyone else for other problems or health conditions? ☐ Yes ☐ No

Please list the problem/s, date problem/s began, and Provider/s treating you for the condition/s:

____

____

Past health history

Have you…	Yes	No	If yes, include date & provider seen
...been diagnosed with Hypertension?	☐	☐	______________________________
...been diagnosed with Diabetes	☐	☐	______________________________
Type I____or Type II_____			

Vitals

Height ________ Weight ________ Blood Pressure ________

Do you smoke? ☐Never ☐Former Smoker ☐Current/Every Day Smoker ☐Current Some Day Smoker

Medications

What medications are you currently taking? Include vitamins, herbs, and minerals…

____

____

____

____

Do you have allergies? (List Allergy and reaction) ☐Food ☐Environmental ☐Medication

____

____