Cayce Chiropractic Center

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Chart Number:_____ Date:_____

1 PATIENT INFORMATION

Name: _____
(First) (Initial) (Last) (Name called by)
Address: _____
_____
Birthday: _____ Age: ____ ☐ Male ☐ Female
Social Security # _____/_____/_____
Occupation: _____
Employer: _____
Parents Name(if a minor):_____
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Seperated
Spouse's Name: _____
# of Children: ___Name(s)_____

2 INSURANCE

Who is responsible for this account?_____
Relationship to patient_____
Insurance company_____
Insurance ID number_____
Group / Claim number_____
Is patient covered by additional insurance? ☐ Yes ☐ No
Insurance company_____
Subscriber # and name_____
Birthdate_____Group #_____
Please present insurance card(s) so we can put a copy in your file.

3 ACCIDENT INFORMATION

Is your condition due to an accident? ☐ No ☐ Yes Date: ____
Type of accident? ☐ Automobile ☐ Work ☐ Home ☐ Other
To whom have you reported the accident?
Insurance ☐ Worker's Comp ☐ Employer ☐ Other_____
Attorney Name (If applicable)_____

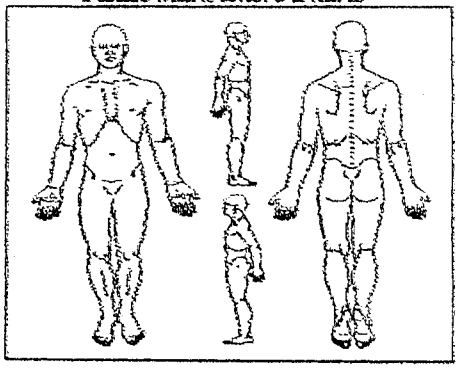
4 CONTACT INFORMATION

Home phone_____
Cell phone_____
Work Phone_____Ext_____
Email_____
Best way to reach you ☐ Home ☐ Cell ☐ Work ☐ Email
IN CASE OF EMERGENCY, CONTACT
Name_____Relationship_____
Home Phone_____Cell_____

5 PATIENT CONDITION

What is your major symptom/problem? _____
When did your symptoms begin? _____
Have you had this problem before? _____
Is your condition getting progressively worse? Yes ☐ No ☐
Is this problem: ☐ constant ☐ comes and goes
How does it Feel? ☐ Burning ☐ Sharp ☐ Shooting ☐ Dull ☐ Aching ☐ Stiff
☐ Tingling ☐ Throbbing ☐ Swelling ☐ Other_____
Circle below the severity of your pain on a scale of 0 to 10:
(No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe pain)
What makes your condition better? _____
What makes your condition worse? _____
Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities/movements that are painful to perform:
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Driving ☐ Reading ☐ Getting Up

Please mark where it hurts



- Please continue on the back -

6 HEALTH HISTORY

What other treatments have you had for this condition?

☐ Chiropractic ☐ Orthopedic ☐ Neurologist ☐ Physical Therapy ☐ Medication ☐ Surgery

Name of other doctors who have treated you for this condition_____

Describe the other doctor's treatment for your condition_____

Previous Chiropractic care? ☐ No ☐ Yes Date_____ ☐ Local ☐ Out of state _____

Date of Last: Physical Exam_____ Spinal x-ray_____ MRI _____

Spinal Exam _____ Dental x-ray_____ CT- Scan _____

List any Medications you are taking_____

Vitamins / Herbs / Minerals _____

Females: Are you Pregnant ☐ Yes ☐ No Beginning of last menstrual cycle_____

Check any of the following conditions you have had:

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anxiety/Depression
- ☐ Arm/shoulder pain
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder problems
- ☐ Cancer
- ☐ Chronic fatigue
- ☐ Deafness
- ☐ Diabetes
- ☐ Digestion problems
- ☐ Earache
- ☐ Ear ringing
- ☐ Epilepsy
- ☐ Headaches
- ☐ Headaches - Migraine
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Herniated disk
- ☐ High blood pressure
- ☐ Insomnia
- ☐ Irregular cycle
- ☐ Kidney problems
- ☐ Leg pain
- ☐ Low back pain
- ☐ Neck pain
- ☐ Osteoporosis
- ☐ Poor circulation
- ☐ Prostate problems
- ☐ Rheumatoid Arthritis
- ☐ Sciatica
- ☐ Shingles
- ☐ Sinus infection
- ☐ Stroke
- ☐ Thyroid problems
- ☐ TMJ
- ☐ Venereal disease
- ☐ Vertigo/Dizziness

STRESSORS

☐ Smoking	Packs/Day	_____
☐ Alcohol	Drinks/Week	_____
☐ Coffee/ Caffeine Drinks	Cups/Day	_____
☐ High Stress Level	Reason	_____

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Have you had any:	**Description**	**Date**
Automobile accidents	_____	_____
Surgeries	_____	_____
Broken bones	_____	_____
Falls/Head injuries	_____	_____

7 AUTHORIZATION

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Cayce Chiropractic Center to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Signature Date Parent (if patient is a minor)

CAYCE CHIROPRACTIC CENTER
1106 12th Street
Cayce, SC 29033

803-796-2424

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Cayce Chiropractic Center or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date