PATIENT HISTORY

What do you prefer to be called: _____
Name: *(First)*_____ *(Last)* _____ *(MI)* _____
Address: _____
City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Patient Social Security # ____ - ____ - ____	Your Age: _____ Married Single Divorced Widowed

Home phone #: ( ) _____ - _____ Work phone #: ( ) _____ - _____
Cell Phone #: ( ) _____ - _____ E-mail address: _____
Patient's Employer: _____ Retired Unemployed Student
Employer's Address: _____ Occupation: _____

Spouse's Name: _____
Spouses Social Security # _____ - _____ - _____ Spouse's Date of Birth: _____/_____/_____
Spouse's Employer: _____ Spouse's Occupation: _____
Name of Person Responsible for this account: _____ Relationship to Patient:_____
Do you have children? Yes / No How many? _____ Ages of Children: _____

IN EVENT OF EMERGENCY
Who should we contact? _____ Relationship to You: _____
Home Ph: #: ( ) _____ - _____ Alt. Ph: #: ( ) _____ - _____

PAIN INTENSITY: Please put a **STAR** on the scale describing the intensity of your pain **RIGHT NOW:**

No Pain 0_____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 **Unbearable Pain**

CONFIDENTIAL HEALTH HISTORY

Please feel free to use the back of this form to provide additional information

Have you ever had surgery or been hospitalized? *Yes / No* **List Surgeries:** _____
_____

Please list any past serious accidents, injuries, or motor vehicle accidents with dates: _____
_____

Please list any medications or vitamins you are currently taking: _____
_____

Please list anything that you may be allergic to: _____

Do you have, or have you ever had any of the following health problems? **(Check all that apply)**

_____ Headaches	_____ Achyness / General Pain	_____ High / Low Blood Pressure	_____ Auto Accidents
_____ Migraine	_____ Difficulty Concentrating	_____ Excessive Sweating	_____ Other Accidents/ Falls
_____ Neck Pain / Stiffness	_____ Memory Loss / Forgetful	_____ Stomach Problems	_____ Sports Injuries
_____ Shoulder Pain / Stiffness	_____ Frequent Colds / Flus	_____ Nausea	_____ Work Injuries
_____ Numbness / Tingling Arm(s)	_____ Nervousness	_____ Ulcers	_____ Fainting
_____ Elbow Pain / Stiffness	_____ Irritability	_____ Liver / Gall Bladder Problems	_____ Depression
_____ Wrist / Hand Pain or Stiffness	_____ Diabetes	_____ Kidney Problems	_____ Mood Disorders
_____ Upper Back Pain or Stiffness	_____ Cancer	_____ Digestion Problems	_____ Emotional Disorders
_____ Mid Back Pain or Stiffness	_____ Vision / Eye Problems	_____ Diarrhea	_____ Tension
_____ Low Back Pain or Stiffness	_____ Hearing / Ear Problems	_____ Constipation	_____ Stress
_____ Hip Pain or Stiffness	_____ Ear Infections	_____ Bladder Problems	_____ Anxiety
_____ Knee Pain or Stiffness	_____ Sinus Problems	_____ Incontinence	_____ Poor Diet
_____ Ankle/Foot Pain or Stiffness	_____ Thyroid Problems	_____ Impotence	_____ Pain w/ coughing
_____ Pain shooting down leg(s)	_____ Allergies	_____ Prostate Problems	_____ Pain w/ sneezing
_____ Trouble Walking	_____ Asthma	_____ Bed Wetting	_____ Pain at stools
_____ Sore Muscles	_____ Trouble Breathing	_____ Menstrual Problems (PMS)	_____ Restricts Daily Activity
_____ Painful Joints	_____ Heart Problems	_____ Fractured Bones	_____ Restricts Exercise
_____ Tiredness / Fatigue	_____ Circulation Problems	_____ Dizziness	_____ Unable to Work

_____ Other Problems not listed: _____

PATIENT'S SIGNATURE _____ DATE _____

Confidential Patient Health Record

Today's Date: ____ / ____ /

WELCOME. The doctor and staff of ***On-Site Mobile Chiropractic*** welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will refer you to the appropriate healthcare provider. If you are a candidate for chiropractic care, then a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS. Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this for, please ask the receptionist for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

PERSONAL INFORMATION

Name: *(First)* _____ *(Middle)* _____ *(Lost)* _____ Jr., II, III, IV

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: ____ / ____ /____ Age: _____ Marital Status *(Circle):* Divorced Married Single Separated Widowed

Gender *(Circle):* Male /Female Home Phone: (____)____ - _____ Cell Phone: (____)_____ - _____

Social Security #: _____-___- _____ Email Address: _____ @_

Spouses Name: _____ Names & Ages of Children: _____

Is your spouse a patient in our office? **(wj Yes** (v) **No** _____

Employer/Employment Status □ Employed □ Unemployed □ Full Tunc / □ Part Time Student □ Other

Business Name: _____ Occupation/Job Title: _____

Business Address: _____

Business Phone: (____) _____-_____ Type of Work: _____

Is it ok to contact you at work? fw) Yes **0** No

Emergency Contact Information

Name: *(First)* _____ *(Middle)* _____ *(Lost)* _____ Jr., II, III, IV

Address: _____ City: _____ State: _____ Zip: _____

Relationship: _____ Home Phone: (_____)_____ - _____ Cell Phone: (__) _____ - _____

Primary Care Physician: _____ Physician Phone: (____) _____-_____

Insurance Information

Who besides yourself is responsible for your bill? I~I Worker's Comp I~I Auto Insurance |~~| Medicare f~1 Medicaid

(U Other *(Be Specific):* _____

Personal Health Insurance Carrier: _____ Health ID Card #: _____

Insured Person's Name: _____ Group #: _____

Insured Person's Date of Birth: ____ /_____/ Insured Person's Social Security #: _____-_____-_____

Referral Information

How did you hear about our office? *(Check)* □ Sign □ Yellow Pages □ Internet □ Referral fJO Other

If referral, who may we thank for referring you? _____

ACCEPTANCE AS A PATIENT. I understand and agree that ***Dr. Bumgarner*** has the right to refuse to accept me as a patient at any time before treatment begins, or terminate my care as a patient if in the course of treatment I am not following Dr. Bumgarner's treatment plan for my condition, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Patient Signature: **Date:** / /