Welcome to Winslow Chiropractic

Please fill out this form as completely and accurately as possible

PERSONAL INFORMATION

Today's Date_____ Preferred Language: _____

Preferred method of communication for patient reminders: ❑Home# ❑ Work# ❑Cell# ❑E-mail ❑ Mail

Full Name_____ DOB _____/_____/_____

Parent's names (if you are under 18) _____

Gender ❑Male ❑Female SS# (opt'l)_____ Marital Status ❑S ❑M ❑D ❑W

Home Address_____ City _____ State_____ Zip _____

Home Phone (____) _____Work Phone (____) _____

Cell Phone (____) _____ E-mail _____

Name of Spouse _____ # of Children _____

Occupation_____ Employer _____

Emergency contact _____ Best # (____) _____

Who is your Medical Doctor: _____ Phone (____) _____

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

CMS requires providers to report both race and ethnicity

Race: ❑ American Indian ❑ Asian ❑ Black or African American ❑ White (Caucasian) ❑ Alaska Native ❑ Native Hawaiian/Pacific Islander ❑ Other ❑ I Decline to Answer

Ethnicity: (Circle one): ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I Decline to Answer

PAYMENT / INSURANCE INFORMATION

Who is responsible for your bill? ❑ Self (cash) ❑ Health Insurance ❑ Medicare ❑ Medicaid ❑ Parent ❑ Worker's Comp. ❑ Auto Insurance ❑ Other _____

Policy Holder's Name: _____ Policy Holder's DOB _____ / _____ / _____

Have you filed a workman's comp report for this injury? ❑Yes ❑No Date: ___/___/___ Time: _____am/pm

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card

PLEASE READ AND SIGN BELOW

Assignment of Benefits and Financial Responsibility – *I certify that I (or my dependent) have insurance coverage with the above insurance company and authorize assignment of my insurance rights and benefits directly to Winslow Chiropractic for medical services and supplies provided to me during all courses of treatment. I understand and agree that this Assignment will have continuing effect for so long as I am being treated or cared for by Winslow Chiripractic. Furthermore, I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible for charges not covered by insurance. If Winslow Chiropractic provided me with a cost estimate based on information they received from my insurance company, this is not a guarantee of coverage. In some cases exact insurance benefits can not be determined until the insurance company receives the claim. I accept and understand that I am financially responsible for the entire balance of the bill if the submitted claim(s) is denied in part or in full.*

Acknowledgement of Notice of HIPAA Privacy Practices – *I have received and /or have been given the opportunity to review Winslow Chiropractic's* ***Notice of HIPAA Privacy Practices*** *for Protected Health Information.*

Consent to Treat – *I hereby give Dr. Thomas Winslow permission to administer chiropractic adjustments, care, therapy and procedures that he determines is necessary and appropriate.*

Patient's Signature _____ Date_____

Parent/Guardian Signature Authorizing Care _____ Date_____

REASON FOR YOUR VISIT

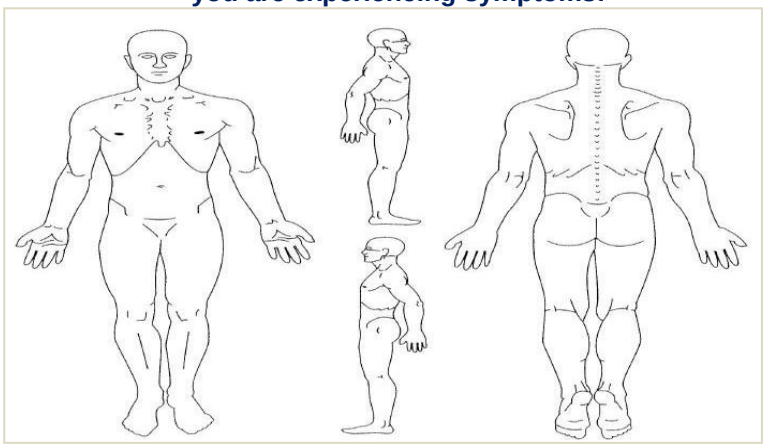
Reason for today's visit: ❑New Injury ❑Old Injury ❑Chronic Pain ❑Wellness ❑Other:_____

Did your injury occur during? ❑ Work ❑ Sports/Play ❑ Auto Accident ❑ Other:_____

When did your condition/accidddent occur: _____/_____/_____ **Please explain what happened:** _____

_____

Indicate on the body diagram where you are experiencing symptoms:



Rate your pain intensity ←no pain to high pain→

0 1 2 3 4 5 6 7 8 9 10

How would you describe the type of pain?

❑Sharp ❑Numb ❑Diffuse
❑Dull ❑Tingly ❑Shooting
❑Burning ❑Stiff ❑Achy

How often do you experience your symptoms?

❑Constantly (76-100% of the time)
❑Frequently (51-75% of the time)
❑Occasionally (26-50% of the time)
❑Intermittently (1-25% of the time)

How are your symptoms changing with time?

❑Getting Worse ❑Same ❑Getting Better

Is your condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine **If so, How?**_____

_____

Who else have you seen for your problem?

❑Primary Care Physician ❑Chiropractor ❑Neurologist ❑Orthopedist
❑Massage Therapist ❑Physical Therapist ❑No one ❑Other:_____

Anything else pertinent to your visit today? _____

_____

HEALTH QUESTIONAIRE

Are you pregnant? Yes_____ No _____ N/A_____

Have you ever **fractured/hurt/injured your** spine, head, neck, ribs, upper or lower back, pelvis or hips? ❑ Y ❑ N

If yes, state ***type of injury and date:*** _____

Have you ever received Chiropractic care? ❑Y ❑ N If yes, approximate date of last visit: _____

Have you ever been hospitalized? ❑ Y ❑ N If yes, ***state reason and dates:*** _____

_____

Have you ever had surgery? (List Date, Reason, Results of Surgery): _____

_____

Are you currently taking any medications? *(Include prescription & regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

Smoking Status: ❑ Every Day Smoker ❑ Occasional Smoker ❑ Former Smoker ❑ Never Smoked

Conditions or Illnesses: *(please check "Past", "Present" or "No" to denote how they apply to you)*

	Past	Present	No		Past	Present	No		Past	Present	No
Stroke				Asthma				HIV/AIDS			
Seizures				Tuberculosis				Cortisone Use			
Head Injury				Emphysema				Sinus Infections			
Brain Aneurysm				Thyroid				Gall Bladder Problems			
Numbness				Diabetes				Liver Problems			
Severe Headaches				Hepatitis				Ulcers			
Pinched Nerves				Blood Clots				Depression			
Parkinson's				Heart Disease				Anxiety			
Vertigo				Hypertension				Kidney Disease			
Arthritis				High Cholesterol							
Osteoporosis				Pace Maker							

Family Medical History – ☑ check *major medical diagnoses for family members below*

No Known Diagnosis	000.00	❑ Father	❑ Mother	❑ Brother	❑ Sister	❑ Son	❑ Daughter
Heart Disease	151.9	❑ Father	❑ Mother	❑ Brother	❑ Sister	❑ Son	❑ Daughter
Diabetes	E11.9	❑ Father	❑ Mother	❑ Brother	❑ Sister	❑ Son	❑ Daughter
Stroke	I63.50	❑ Father	❑ Mother	❑ Brother	❑ Sister	❑ Son	❑ Daughter
Cancer	C80.1	❑ Father	❑ Mother	❑ Brother	❑ Sister	❑ Son	❑ Daughter

Please comment on any additional health history or information you feel is important for us to know:

_____

_____

_____

☐ **Check here if you choose to decline receipt of your clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

For office use only: Height: _____ Weight:_____ Blood Pressure:_____ /_____