

Bandana Chiropractic & Wellness Center Patient History

(Please Print, All information is confidential)

Date: _____

Name: _____

Referred By: _____

Address: _____

Marital Status: M S D W # of Children: _____

City, State, Zip: _____

Spouse's Name _____

Home Phone: () _____

Cell Phone: () _____

Office Phone: () _____

Occupation: _____

E-mail: _____

Employer: _____

DOB: _____ Age: _____

If patient is a minor (under 18yrs old), Please fill out this section. If not, skip:

Parent/ Guardian's Name: _____

Date of Birth: _____ Age: _____

Address: _____

City/State: _____ Zip: _____

Phone # _____ SS# _____

Have Insurance

No Insurance

Insurance Name: _____

Policy/ Card # _____

Secondary: _____

Policy/ Card # _____

Please present insurance card(s) to the front desk, so we can copy them.

Group # _____

Please present your insurance card and picture ID to the front desk

Chief complaint or reason for today's visit?

How long have you had this condition? _____ Date of Onset? _____ Cause? _____

Have you had this condition before? _____ If yes, when? _____

Is the condition related to: Work () Auto () Date of Accident: _____ Have you lost days from work? _____

What doctors have you seen for this condition? _____

What did they do? _____

When was your last visit to a Chiropractor? _____ Chiropractor's Name _____

What are your health goals? _____ Smoker / Non Smoker

What surgeries have you had? _____

List drugs you now take (prescription & non-prescription): _____

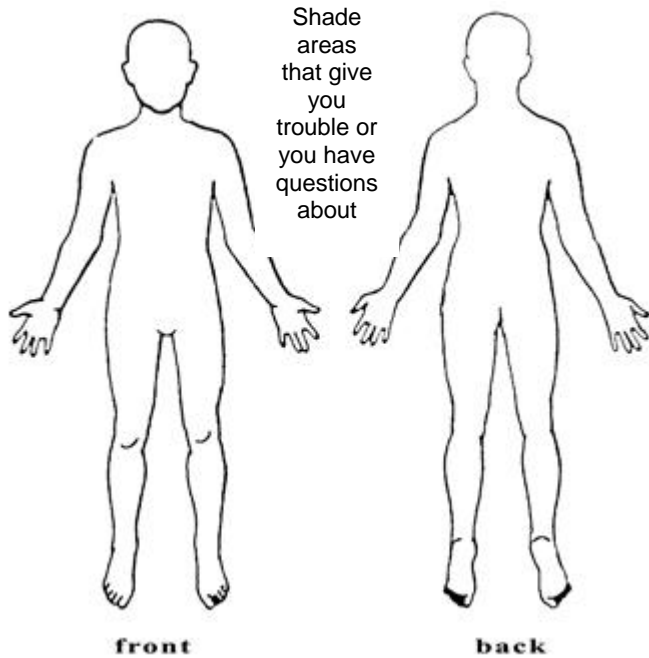
When was your last auto accident? _____

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Please mark C for current and P for past conditions

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Numb/ Tingle Pain arms, hands, fingers | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Pain w/ Cough/ Sneeze |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Foot Trouble |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Swollen/ Painful Joints | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Numb/ Tingle Pain legs, feet, toes | <input type="checkbox"/> Frequent Colds/ Flu | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Convulsions/ Epilepsy | <input type="checkbox"/> Difficulty bending or with Household duties | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Cancer | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart Problem |
| <input type="checkbox"/> Difficulty standing, Walking, or Sitting | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Jaw Pain, TMJ, R L | <input type="checkbox"/> Menstrual Problem |
| <input type="checkbox"/> Difficulty with daily activities | <input type="checkbox"/> Depression | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Difficulty exercising | <input type="checkbox"/> Irritable | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Impotence/ Sexual Dysfunction | <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Fractured Bones | <input type="checkbox"/> Tremors | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Auto Accidents | <input type="checkbox"/> Allergies | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Other Accidents/ Falls | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Diarrhea/ Constipation |
| <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Menopausal Problems |
| <input type="checkbox"/> Pregnant (Now) | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> AIDS/ HIV |
| <input type="checkbox"/> ADD/ ADHD | <input type="checkbox"/> Hepatitis (A,B,C) | <input type="checkbox"/> PMS | <input type="checkbox"/> Skin Problems |



Family Health History

Has anyone in your IMMEDIATE family had any of the following conditions:

- | | |
|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Muscular Sclerosis | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Neuritis |
| <input type="checkbox"/> Spine Problems | <input type="checkbox"/> Pinched Nerves |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Asthma-Hay Fever | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Stomach Trouble |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Disc Problems | |

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THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE.

POLICIES

1. All first visit charges are payable when services are rendered, since it is impossible to determine what insurance covers without a complete evaluation.
2. The fee paid for X-rays is for the analysis of those X-rays only. The film itself is the property of this office. Original X-rays cannot be released.
3. I understand that there will be no fees charged if I give 24 hours notice to cancel or reschedule an appointment

Informed Consent: A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical produces are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Bandana Chiropractic and Wellness Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustment of the spine.

Health: A state of healing and functioning at 100%; physical, mental and social well being, not merely the absence of disease, symptoms or infirmity.

Vertebral Subluxations: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to heal and function at 100%.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings we will so advise you. If you desire advice, diagnosis, or treatment for those findings we will recommend you seek the services of the health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate interference to the expression of the body's innate healing power. Our only method is the specific correction of vertebral subluxations.

Legal Assignment of Benefits and Release of Medical and Plan Documents

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Bandana Chiropractic and Wellness Center all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, choose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Privacy Policy: I have read Bandana Chiropractic and Wellness Center's Notice of Patient Privacy Practices.

I have read and fully understand the above statements.

Signature of Insured/Guardian

Date

In case of emergency, notify _____ **Phone #** _____

COMPLETE IF THE PATIENT IS A MINOR CHILD: child's name: _____

I, _____ being the parent or legal guardian of the aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

(Signature) _____(Date)