

Heart of Dixie Chiropractic

Patient Information

(Please Do Not Leave Any Spaces Blank)

Personal Information

Date of Exam: ___/___/___

Name (F) _____ (M) _____ (L) _____
Address _____ City/State _____ Zip _____
Cell Phone _____ Work Phone _____ Text reminders (circle one) YES NO
Birth date _____ Age _____ Gender (circle one) M F Marital Status (circle one) S M W
SSN # _____ Your Email _____
Spouse's Name _____ Spouse's Contact Phone (for emergencies) _____
Spouse's Birth date _____
Emergency Contact _____ Relationship _____ Phone _____
Your Employer _____ Occupation _____ Work Phone _____
How were you referred to our office? (circle one) another patient, attorney, doctor, sign, I am a current patient, other _____
Have you had chiropractic care with another doctor? (circle one) Yes / No If yes when? _____
Have you had X-rays, MRI, or CT Scan of your spine in the past two years? (circle one) Yes / No If yes, where? _____
General Physician _____ General Physician's Phone _____
I hereby authorize and direct you, Bryant Chiropractic Clinic, to release my examination notes to my general physician for his/her use only.
Signature _____

Your Symptoms

A. List your chief complaint (s) (up to four) **in order of severity**: (examples: Headaches, Neck pain, Back pain, Arm pain, Leg pain, etc.)

1. _____ When and Why did it start? _____
2. _____ When and Why did it start? _____
3. _____ When and Why did it start? _____
4. _____ When and Why did it start? _____

Comments _____

B (Examples: Ice, Heat, Advil, Aleve, etc.)

(Examples: Sitting, Bending, Lifting, Sleeping, Turning, etc.)

1. What makes it better? _____ Worse? _____
2. What makes it better? _____ Worse? _____
3. What makes it better? _____ Worse? _____
4. What makes it better? _____ Worse? _____

Comments _____

C. (circle one)

- | | | | | | |
|-----------------|----------|----|--------------|------------------------|-------|
| 1. Is the pain? | Constant | or | intermittent | How long does it last? | _____ |
| 2. Is the pain? | Constant | or | intermittent | How long does it last? | _____ |
| 3. Is the pain? | Constant | or | intermittent | How long does it last? | _____ |
| 4. Is the pain? | Constant | or | intermittent | How long does it last? | _____ |

Comments _____

D.

1. Does the pain radiate down your arm or leg? (no, yes / explain) _____
2. Does the pain radiate down your arm or leg? (no, yes / explain) _____
3. Does the pain radiate down your arm or leg? (no, yes / explain) _____
4. Does the pain radiate down your arm or leg? (no, yes / explain) _____

Comments _____

E. (Please use a number from 0 to 10 or a combination of numbers, example: 3-5)

1. How severe is the pain? (0-no pain 10-severe pain) _____
2. How severe is the pain? (0-no pain 10-severe pain) _____
3. How severe is the pain? (0-no pain 10-severe pain) _____
4. How severe is the pain? (0-no pain 10-severe pain) _____

Comments _____

F. (circle one)

- | | | | |
|-----------------|---------------------|-------|-------|
| 1. Is the pain? | Sharp / Dull / Both | Other | _____ |
| 2. Is the pain? | Sharp / Dull / Both | Other | _____ |
| 3. Is the pain? | Sharp / Dull / Both | Other | _____ |
| 4. Is the pain? | Sharp / Dull / Both | Other | _____ |

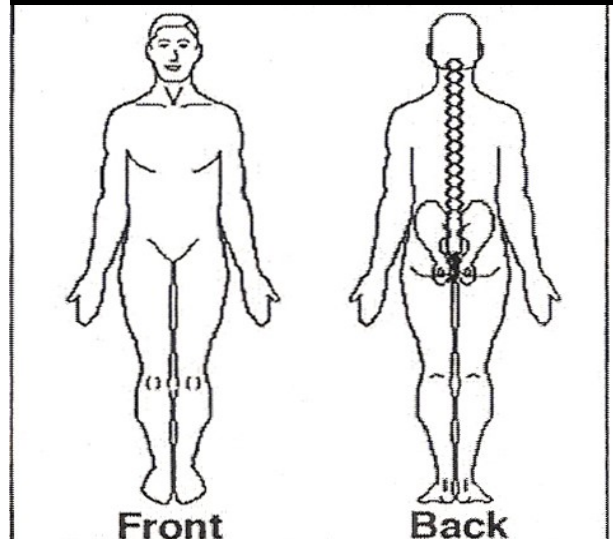
Comments _____

G.

1. Have you ever had similar symptoms? (yes/no) _____
2. Have you ever had similar symptoms? (yes/no) _____
3. Have you ever had similar symptoms? (yes/no) _____
4. Have you ever had similar symptoms? (yes/no) _____

Comments _____

Mark your Area(s) of symptom(s)
Pain = X Numbness or Tingling = O



PLEASE COMPLETE THE REVERSE SIDE

H. How has this current condition(s) affected your:

1. Home Life? _____
2. Occupational life? _____
3. Recreational life? _____
4. Rest and sleep life? _____

Medical History

Major Surgeries: _____

Current Medication/dosage _____

History of Cancer: _____

Are you HIV positive? (circle one) Yes No If yes, how long? _____

Family history of cancer/heart disease/diabetes _____

Other: _____

Work Accident - Are you being evaluated **today** due to a work accident? ___ Yes ___ No (If yes, please fill out the following)

Date of accident ____ / ____ / ____ Did you report this injury to your employer? Yes _____ No _____

Describe your accident _____

Employer name _____ Address _____

Manager's name _____ Phone _____

Workers Compensation carrier _____ Phone _____

How many days of work have you lost? (give dates) _____

Automobile Accident - Are you being evaluated today due to an automobile accident? ___ Yes ___ No (If yes, fill out the following)

Date of accident ____ / ____ / ____ Were you issued a traffic citation? (circle one) Yes No

Describe your accident in detail _____

Your vehicle was a _____ The other vehicle was a _____

How was your vehicle struck? (circle one) Front Rear R-side L-side R-Front corner L-Front corner R-Rear corner L-Rear corner

Your position in the car (circle one) Driver Passenger Front seat Rear seat

Were your brakes applied at the time of the accident? (circle one) Yes No

Were you wearing your seat belt? (circle one) Yes No

Did your seat break? (circle one) Yes No

Did you hit any object in the car? _____

Did you sustain any bruises or cuts? (explain) _____

Did you go to the hospital after the accident? Yes No How did you get there? Ambulance Drove myself Someone drove me

Name of Hospital _____

Treatment received since accident? Yes No Doctor's name _____

Have you lost any days of work unpaid since accident? (give dates) _____

Do you have an attorney? Yes No Attorney's name _____

Attorney's Address _____ Phone _____

Insurance company responsible _____

Address _____ Phone _____

Your car insurance _____

Address _____ Phone _____

MEDPAY claim # _____

(We do not file third party claims. We file with your auto insurance MedPay or your medical insurance/ You are responsible for all services received that the insurance does not cover.)

Assignment, Lien, Authorization For Insurance Benefits, and Power Of Attorney

I hereby authorize and direct my insurance company and/or my attorney to pay Heart of Dixie Chiropractic, located at 1600 Sparkman Drive, NW, Huntsville, AL 35816, directly for any amounts owed for services rendered to me due to an accident or illness. This authorization includes withholding these amounts from any disability benefits, workers' compensation benefits, no-fault benefits, health and accident benefits, or any other benefits obligated to reimburse me, as well as from any settlement, judgment, or verdict on my behalf, as necessary to adequately protect the office. I understand that I remain personally responsible for the total amounts due to the office for services rendered. I also acknowledge that if I decide to change chiropractors before my personal injury case is settled, I will be required to pay all amounts owed within seven working days of changing providers. Furthermore, I grant Heart of Dixie Chiropractic Power of Attorney solely for the purpose of endorsing any negotiable instruments payable to this clinic for services rendered. I authorize Heart of Dixie Chiropractic to release any pertinent information regarding my case to any insurance company, adjuster, or attorney to facilitate the collection process under this assignment, lien, and authorization. I agree to pay for any attorney or collection agency fees incurred due to my failure to pay amounts due in a timely manner. If this account is turned over to an attorney for collection, I agree to pay all associated costs, including a reasonable attorney's fee or a reasonable percentage charged for the collection process. I acknowledge that a photocopy of this document will be considered valid and binding on all parties as the original copy.

Signature _____ Employee _____ Date ____ / ____ / ____

Signature