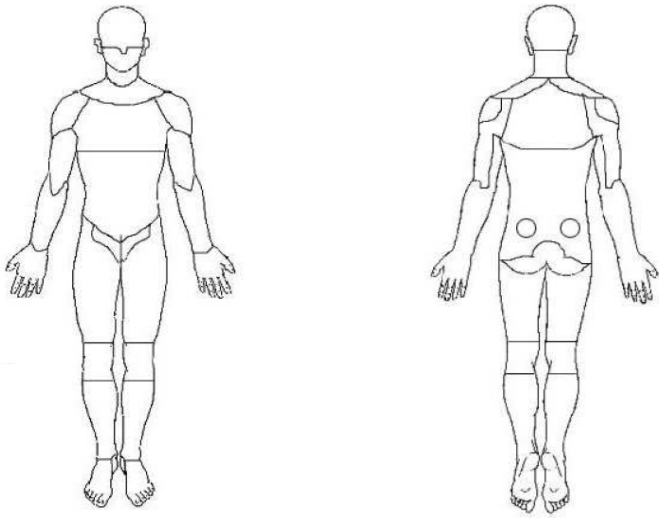
Please indicate ALL areas of complaint on the body diagram below:



Circle your pain on a scale of 1-10:

1 2 3 4 5 6 7 8 9 10

Describe your symptoms: _____

_____

How/When did your symptoms start? _____

_____

How often do you experience your symptoms? (Circle One)

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

How are your symptoms changing?

○ Getting better ○ Not changing ○ Getting worse

What makes your symptoms better? Worse? _____

Have you had this or a similar condition in the past? _____

_____

Have you previously had treatment for this issue?_____

Have you been to a chiropractor before?_____

Last time you had spinal x-rays? _____

What is your goal for consulting with the doctor?

○ Temporary Relief ○ Lasting Correction ○ Let doctor recommend the best type of care for you

Sign: _____ **Date:** _____

Thank you. Please return to the front desk.

PROSPER CHIROPRACTIC & WELLNESS CENTER
PATIENT REGISTRATION & HISTORY

1 PATIENT INFORMATION

Date _____/_____/_____

Legal Name_____

Preferred Name_____

SSN_____

Address _____

City_____State _____Zip_____

Phone (_____)_____

Cell (_____)_____

Work (_____)_____

E-mail _____

Sex ○ Male ○ Female Age _____

DOB _____/_____/_____

○ Married ○ Single ○ Widowed

○ Separated ○ Divorced ○ Minor

Occupation _____

Employer/School_____

Whom may we thank for referring you to our office?

_____

2 INSURANCE INFORMATION

Policy Holder's Name_____

Relationship to Patient _____

DOB _____/_____/_____

SSN _____

Insurance Company_____

ID# _____ Group #_____

AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand and agree to allow this chiropractic office to use my Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate the schedule of care that has been determined by my treating doctor, any fees for professional services will be immediately due and payable.

In addition, I have the right to know how my PHI is going to be used in this office and my rights concerning those records. I understand that if I would like a more detailed account of the office's policies and procedures concerning the use and privacy of my PHI, I should read the HIPAA NOTICE, available at the front desk, prior to signing this consent. I will inform the office if there is anyone to whom I do not wish my medical records be sent.

_____

SIGNATURE of Patient, Parent, Guardian, or Personal Representative

_____

PRINTED NAME of Patient, Parent, Guardian, or Personal Representative

_____ _____

Date Relationship to Patient

3 EMERGENCY CONTACT

In the event we would need to communicate your healthcare information, to whom may we do so?

Name _____

Relationship_____Phone (____)_____

Name _____

Relationship_____Phone (____)_____

4 PRIMARY CARE PHYSICIAN

Practice Name_____

Physician's Name _____

Phone (_____)_____

How long have you been a patient with them?

_____

5 MEDICATIONS / ALLERGIES / ETC

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____