WOOD CHIROPRACTIC
Your Trusted Family Chiropractor

Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ E-mail: _____

What is the number one thing that bothers you the most today? _____

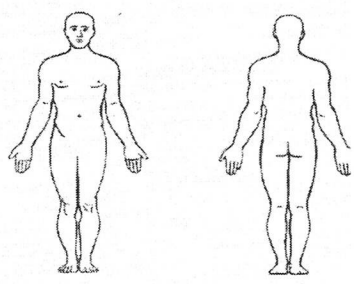
_____

How and when did this begin? _____

_____

Pain Level: 0 1 2 3 4 5 6 7 8 9 10 on and off constant

Where does it bother you most? _____



Type of pain: sharp stabbing burning achy dull stiff & sore

Radiating: left / right skull shoulder arm leg

hand hip knee foot ribs other

Are you? getting better staying the same getting worse

What makes it better? ice heat rest movement stretching other: _____

Worse? sitting standing walking lying down sleep overuse other: _____

Have you seen anyone else for this condition? _____

Any other treatments? _____

Any history with Chiropractic? _____

Were you involved in an accident? auto work accident fall other: _____

_____

List of prescription medications: _____

List of past Surgeries: _____

_____

Do you have any other physical complaints? _____

_____

How did you hear about us? _____

Any Insurance? Company: _____ please provide your card _____ ID# _____

WOOD CHIROPRACTIC
Your Trusted Family Chiropractor

Wood Chiropractic
Medical History Form

Full Name: _____

Today's Date: _____

Personal Medical History: Have you ever had any of the following conditions? (Check if yes)

[ ] Headache
[ ] Neck pain
[ ] Neck stiff
[ ] Sleeping problems
[ ] Back pain
[ ] Nervousness
[ ] Tension
[ ] Irritability
[ ] Chest pain
[ ] Dizziness
[ ] Head seems too heavy
[ ] Pins & needles in Arms
[ ] Pins & needles in Legs
[ ] Numbness in finger
[ ] Numbness in toes
[ ] Shortness of breath
[ ] Fatigue
[ ] Depression
[ ] Light bothers eyes
[ ] Loss of memory
[ ] Ears ring
[ ] Face flushed
[ ] Buzzing in ears
[ ] Loss of balance
[ ] Fainting spells
[ ] Loss of smell
[ ] Loss of taste
[ ] Diarrhea
[ ] Feet cold
[ ] Hands cold
[ ] Stomach upset
[ ] Constipation
[ ] Cold sweats
[ ] Fever
[ ] _____

List names and dates of surgeries:

_____

_____

Medications/Supplements:

_____

_____

Allergies:

_____

For women: Any chance of pregnancy? ☐ Yes ☐ No

Family History: Has anyone in your family had any of the following conditions? (Check if yes, and indicate relationship to you)

☐ Cancer/Polyps_____ Colon, Rectum, Anal, Stomach, Breast, Prostate, Uterus, Ovaries, Thyroid, Lung, Blood, Lymphoma Other _____	☐ Anemia_____ ☐ Diabetes_____ ☐ Blood Clots_____ ☐ Heart Disease _____ ☐ Stroke_____	☐ High Blood Pressure_____ ☐ Anesthesia Reaction _____ ☐ Bleeding Problems_____ ☐ Hepatitis_____ ☐ Other_____

WOOD CHIROPRACTIC
Your Trusted Family Chiropractor

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

- The practice reserves the right to change the privacy policy as allowed by law.

- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **YES NO**

May we leave a message on your answering machine at home or on your cell phone? **YES NO**

May we discuss your medical condition with any member of your family? **YES NO**

If YES, please name the members allowed:_____

Signature: _____ Date: _____