



# PATIENT DEMOGRAPHICS

PLEASE PRINT AND FILL OUT COMPLETELY

Name \_\_\_\_\_ Phone \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status: S M D W

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

How Many Children \_\_\_\_\_ Name of Spouse \_\_\_\_\_

Spouse Date of birth: \_\_\_\_\_ Spouse Employer \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Referred by \_\_\_\_\_ (List person's name, location, or event)

Date of last Physical Examination \_\_\_\_\_

Purpose of this Appointment \_\_\_\_\_

Other Doctors seen for this condition \_\_\_\_\_

Have you been treated for any health condition by a physician in the last year Yes \_\_ No \_\_

Describe: \_\_\_\_\_

Remarks and additional information (if female, is there any possibility you may be pregnant?) \_\_\_\_\_

## **PAYMENT IS EXPECTED AT TIME OF VISIT.**

Person Responsible for Payment \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

**I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In addition, I authorize this facility to release any information acquired in the course of my treatment to my insurance carrier(s) as necessary to process my insurance claim.**

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

GUARDIAN/PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## Case History

Name \_\_\_\_\_ Date \_\_\_\_\_

Have you ever received Chiropractic Care? Yes/No When? \_\_\_\_\_

### Primary reasons for seeking chiropractic care:

Primary reason: \_\_\_\_\_

Secondary reason: \_\_\_\_\_

Other factors contributing to the primary and secondary reasons: \_\_\_\_\_

**Chief Complaint:** \_\_\_\_\_

Complaint started when and how? \_\_\_\_\_

Quality of complaint/pain (circle): Dull Ache Sharp Shooting Burning Throb Other \_\_\_\_\_

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? \_\_\_\_\_

Do you have any numbness or tingling in your body? Where? \_\_\_\_\_

Grade Intensity/Severity (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain imaginable)

How frequent is complaint present, how long does it last? \_\_\_\_\_

Does anything aggravate the complaint? \_\_\_\_\_

Does anything make the complaint better? \_\_\_\_\_

**Dr Notes:** \_\_\_\_\_

**Secondary Complaint:** \_\_\_\_\_

Complaint started when and how? \_\_\_\_\_

Quality of complaint/pain (circle): Dull Ache Sharp Shooting Burning Throb Other \_\_\_\_\_

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? \_\_\_\_\_

Do you have any numbness or tingling in your body? Where? \_\_\_\_\_

Grade Intensity/Severity (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain imaginable)

How frequent is complaint present, how long does it last? \_\_\_\_\_

Does anything aggravate the complaint? \_\_\_\_\_

Does anything make the complaint better? \_\_\_\_\_

**Dr Notes:** \_\_\_\_\_

**Previous treatments, medications, surgery, or care you've sought for your complaints:**

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Name \_\_\_\_\_ Date \_\_\_\_\_

Circle what you are currently experiencing:

- |               |                    |                  |                 |                   |
|---------------|--------------------|------------------|-----------------|-------------------|
| Dizziness     | Depression         | Kidney Stones    | Liver Disease   | Nervousness       |
| Headaches     | Thyroid Problems   | Mid Back Pain    | Shoulder Pain   | Epilepsy          |
| Vertigo       | Asthma             | Irritable Bowl   | Chronic Fatigue | Knee Pain         |
| Ear Infection | Ulcer              | Sciatica         | Lupus           | Infertility       |
| Nausea        | Numbness in Arms   | Numbness in Legs | Fibromyalgia    | Gastric Reflux    |
| TMJ           | Numbness in Hands  | Numbness in Feet | Chest Pain      | Neck Pain         |
| Low Back Pain | Menstrual Disorder | Migraines        | Heart Disorder  | Hip Pain          |
| ADD/ADHD      | Anxiety            | Stomach Disorder | Bladder Problem | Chronic Sinusitis |

Other: \_\_\_\_\_

**Past Health Information**

Circle any condition you have now/ have had:

- |                 |          |               |                |
|-----------------|----------|---------------|----------------|
| Stroke          | Cancer   | Heart Disease | Spinal Surgery |
| Spinal Fracture | Seizures | Scoliosis     | Diabetes       |

List all Surgical Operations and Years: \_\_\_\_\_

List ALL over the Counter & Prescription medications you are on: \_\_\_\_\_

When was your last Auto Accident? \_\_\_\_\_

Have you ever had previous Chiropractic Care? YES NO

If so, by whom and when? \_\_\_\_\_

Have you ever been knocked Unconscious? YES NO Fractured a Bone? YES NO

If yes, Please Describe: \_\_\_\_\_

Other Trauma: \_\_\_\_\_

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both the Doctor and the Patient to be working towards the same objective. This will prevent any confusion or disappointment.

**ADJUSTMENT:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine.

**HEALTH:** A state of optimal physical, mental and social well being, not merely the absence of symptoms or disease.

**VERTEBRAL SUBLUXATION:** A misalignment of one or more of the 24 vertebra 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 express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than musculoskeletal/ nervous system. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you.

We do not offer advice regarding treatment prescribed by others. Cowgill Chiropractic's objective is to eliminate interference with the nervous system. Our method is specific joint adjusting to correct vertebral subluxations. Therapy is available to decrease the musculoskeletal agitation to the spine.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

I, \_\_\_\_\_ have read and fully understand the above statements.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### **Notice of Privacy Practices Acknowledgement**

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

\_\_\_\_\_  
Print Name Here

\_\_\_\_\_  
Signature (Minor must have Parent/Guardian sign)

\_\_\_\_\_  
Date

### Release of Information

If you would like Cowgill Chiropractic to release account information to someone other than yourself, please provide the name of that person below and sign.

Person's Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

## X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF THE X-RAY REPORTS IN OUR FILES.

**PLEASE NOTE:** X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF COWGILL CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

**BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS**

PRINTED NAME \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_ YOUR AGE \_\_\_\_\_

**FEMALE PATIENTS ONLY:** TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT COWGILL CHIROPRACTIC.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE**

Name:					
Acct #:					
Date:					
Cerv. A-P	Cerv Lat	Thor A-P	Thor Lat	Lumbar A-P	Lumbar Lat