

1130 Westport Suite 5 Manhattan, KS 66502

611 Lasley St. Mary’s, KS 66536

**Patient Health History**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last Name) (First Name) (Middle Init.)

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City) (State) (Zip)

Physical Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if address isPO Box) (City) (State) (Zip)

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone**/**carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I would like to receive reminders via- **🞏** Text **🞏** Email **🞏** Neither Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Whom may we thank for referring you to us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

Sex: 🞏 Male **🞏** Female Age:\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_SSN#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: **🞏** Single **🞏** Married **🞏** Widowed **🞏** Divorced **🞏** Separated **🞏** Partner

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

**IN CASE OF EMERGENCY, CONTACT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Name) (Relationship)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Home Phone) (Work Phone) (Cell Phone)

**Insurance Information:**

Primary Ins. Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy/ID #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber’s SSN#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Is patient covered by additional insurance?*** **🞏** Yes **🞏** No

Secondary Ins. Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy/ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber’s SSN#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is the responsible party for this account?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible party’s address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City) (State) (Zip)

**Accident Information:**

Is your condition due to an accident? **🞏** Yes **🞏** No *\*****If yes, please see front desk for additional forms.***

Type of accident: **🞏** Auto **🞏** Work **🞏** Home **🞏** Other State/time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To whom have you made a report of your accident?

**🞏** Auto Insurance **🞏** Employer **🞏** Workers comp. **🞏** Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attorney’s Name (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment and Release:**

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_\_\_

and assign directly to Chiropractic Natural Health Care all insurance benefits, if any, otherwise payable to me for services rendered.  **I understand that I am financially responsible for all charges whether or not paid by insurance**. I hereby authorize Chiropractic Natural Health Care, Inc., to release all information necessary to secure the payment of benefits.

***I authorize the use of this signature on all insurance submissions.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Responsible Party’s Signature) (Relationship to Patient) (Date)

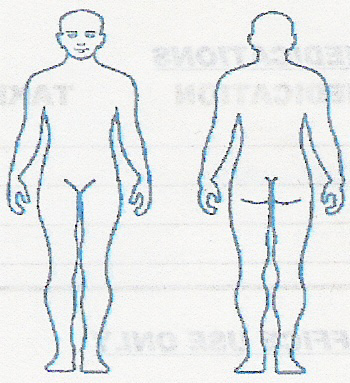
**Patient Condition:**

Reason for patient’s visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your symptoms begin?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this condition getting worse? **🞏** Yes **🞏** No **🞏** Unknown

***Mark an X on the picture where you continue to have pain, numbness, or tingling.***

A.) Rate the severity of your pain on the scale:

(least pain) 1 -----2-----3----4-----5------6-----7----8-----10 (most pain)

B.) Type of pain:

**🞏** Sharp **🞏** Dull **🞏** Throbbing **🞏** Numbness **🞏** Burning

**🞏** Aching **🞏** Shooting **🞏** Tingling **🞏** Cramps **🞏** Stiffness

**🞏** Swelling **🞏** Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

C.) How often do you have this pain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.) Is it constant or does it come and go?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E.) Does it interfere with your:

**🞏** Work **🞏** Sleep **🞏** Daily Routine **🞏** Recreation

F.) Activities or movements that are painful to perform:

**🞏** Sitting **🞏** Standing **🞏** Walking **🞏** Bending **🞏** Lying Down

**Health History:**

Have you ever seen a Chiropractor before? **🞏** Yes **🞏** No

What treatment have you already received for your condition?

**🞏** Medications **🞏** Surgery **🞏** Physical Therapy **🞏** Chiropractic Services **🞏** None

**🞏** Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of 1st Treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of treatment in last 12 months:\_\_\_\_\_\_\_\_\_\_\_

Date of Last: Physical Exam\_\_\_\_\_\_\_\_\_Spinal X-Ray\_\_\_\_\_\_\_\_MRI, CT, Bone Scan\_\_\_\_\_\_\_\_\_\_

**Please select symptoms you currently have:**

**🞏** Balance Impairment **🞏** Lightheadedness **🞏** Ringing/Buzzing in Ears

**🞏** Burning Eyes **🞏** Loss of Concentration **🞏** Visual/Sensory Disturbance

**🞏** Depression **🞏** Loss of Memory **🞏** Vertigo

**🞏** Headaches **🞏** Nausea

**Please select conditions or symptoms you currently have OR have had in the past.**

**🞏** AIDS/HIV **🞏** Diabetes **🞏** Jaw Pain/TMJ **🞏** Rheumatic Fever

**🞏** Anemia **🞏** Emphysema **🞏** Kidney Disease **🞏** Rheumatoid Arthritis

**🞏** Anorexia **🞏** Epilepsy **🞏** Liver Disease **🞏** Scarlet Fever

**🞏** Appendicitis **🞏** Glaucoma **🞏** Mononucleosis **🞏** Stroke

**🞏** Arthritis **🞏** Goiter **🞏** Multiple Sclerosis **🞏** Thyroid Problems

**🞏** Asthma **🞏** Gout **🞏** Osteoporosis **🞏** Tuberculosis

**🞏** Blood Clots **🞏** Heart Disease **🞏** Pacemaker **🞏** Tumors/Growths

**🞏** Breast Lump **🞏** Hepatitis A, B or C **🞏** Parkinson’s Disease **🞏** Varicose Veins

**🞏** Bronchitis **🞏** Hernia **🞏** Pinched Nerve **🞏** Whiplash

**🞏** Bulimia **🞏** Herniated Disc **🞏** Pneumonia **🞏** Ulcers

**🞏** Cancer **🞏** Herpes **🞏** Polio **🞏** Other:\_\_\_\_\_\_\_\_\_\_\_\_

**🞏** Cataracts **🞏** High Blood Pressure **🞏** Prosthesis **🞏** Other:\_\_\_\_\_\_\_\_\_\_\_\_

**🞏** Chemical Dependency **🞏** High Cholesterol **🞏** Psychiatric Care **🞏** Other:\_\_\_\_\_\_\_\_\_\_\_\_

**Women only:** Are you pregnant? **🞏** Yes **🞏** No Due Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Life Habits:**

Alcohol **🞏** None **🞏** Light **🞏** Moderate **🞏** Heavy

Caffeine  **🞏** None **🞏** Light **🞏** Moderate **🞏** Heavy

Tobacco **🞏** None **🞏** Light **🞏** Moderate **🞏** Heavy

Drugs **🞏** None **🞏** Light **🞏** Moderate **🞏** Heavy

Exercise **🞏** None **🞏** Light **🞏** Moderate **🞏** Heavy

Home Stress **🞏** None **🞏** Light **🞏** Moderate **🞏** Heavy

Work Stress **🞏** None **🞏** Light **🞏** Moderate **🞏** Heavy

Other Stress **🞏** None **🞏** Light **🞏** Moderate **🞏** Heavy

(Reason\_\_\_\_\_\_\_\_)

**Work Activity:**  **🞏** Sitting **🞏** Standing **🞏** Light Labor **🞏** Heavy Labor

Please **describe and date** any auto accidents/injuries, head injuries, broken bones, dislocations, and surgeries you have had in the past:

Any other major medical information you would like the doctor to know about:

**Allergies**

**Medications Taking For**

**Vitamins/Supplements**



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Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

|  |  |
| --- | --- |
| **First Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Last Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Email address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred method of communication for patient reminders** (Circle one):Email / Phone / Mail

**DOB:**  \_\_/\_\_/\_\_\_**Gender (Circle one):**  Male / Female **Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_**

***Smoking Status (Circle one*):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

*CMS requires providers to report both race and ethnicity*

***Race (Circle one):*** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

***Ethnicity (Circle one):***Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications?**

(Please include regularly used over the counter medications)

|  |  |
| --- | --- |
| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
|  |  |
|  |  |
|  |  |

**Do you have any medication allergies?**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name | Reaction | Onset Date | Additional Comments |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Check this box if you choose to decline receipt of your clinical summary after every visit**

*(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Height: \_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_ Blood Pressure:\_\_\_\_\_\_ /\_\_\_\_\_\_ HR\_\_\_\_\_\_\_ |