

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Reason for this Appointment: \_\_\_\_\_

Condition(s) Symptoms / Pain You Are Currently Experiencing: \_\_\_\_\_

Are you Pregnant?  Yes  No

Answer Yes (Y) or No (N) if you have ever had the following health facts:

- |   |  |   |   |  |
|---|--|---|---|--|
| Y N   | Y N  | Y N   | Y N   | Y N  |
| <input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Hearing Problem      | <input type="checkbox"/> <input type="checkbox"/> Stomachache               | <input type="checkbox"/> <input type="checkbox"/> Concussion                    | <input type="checkbox"/> <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> <input type="checkbox"/> Fever                   | <input type="checkbox"/> <input type="checkbox"/> Loss of Smell        | <input type="checkbox"/> <input type="checkbox"/> Ulcers                    | <input type="checkbox"/> <input type="checkbox"/> Head or Neck Pain             | <input type="checkbox"/> <input type="checkbox"/> Memory Loss          |
| <input type="checkbox"/> <input type="checkbox"/> Weight Loss             | <input type="checkbox"/> <input type="checkbox"/> Sinus Trouble        | <input type="checkbox"/> <input type="checkbox"/> Intestinal Pain           | <input type="checkbox"/> <input type="checkbox"/> Pain in Extremities           | <input type="checkbox"/> <input type="checkbox"/> Depression           |
| <input type="checkbox"/> <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> <input type="checkbox"/> Trouble Swallowing   | <input type="checkbox"/> <input type="checkbox"/> Trouble Urinating         | <input type="checkbox"/> <input type="checkbox"/> Pain in Spine, Ribs or Pelvis | <input type="checkbox"/> <input type="checkbox"/> High/Low Blood Sugar |
| <input type="checkbox"/> <input type="checkbox"/> Numbness                | <input type="checkbox"/> <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> <input type="checkbox"/> Rectal Bleeding           | <input type="checkbox"/> <input type="checkbox"/> Breast Soreness               | <input type="checkbox"/> <input type="checkbox"/> Swollen Glands       |
| <input type="checkbox"/> <input type="checkbox"/> Vision Problems         | <input type="checkbox"/> <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> <input type="checkbox"/> Bladder Infection         | <input type="checkbox"/> <input type="checkbox"/> Nipple Soreness               | <input type="checkbox"/> <input type="checkbox"/> Anemia               |
| <input type="checkbox"/> <input type="checkbox"/> Dizziness               | <input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> <input type="checkbox"/> Broken or Fractured Bones | <input type="checkbox"/> <input type="checkbox"/> Anxiety                       | <input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding   |
| <input type="checkbox"/> <input type="checkbox"/> Earache                 | <input type="checkbox"/> <input type="checkbox"/> Excessive Coughing   | <input type="checkbox"/> <input type="checkbox"/> Backache                  | <input type="checkbox"/> <input type="checkbox"/> Neuritis                      | <input type="checkbox"/> <input type="checkbox"/> Allergies            |
| <input type="checkbox"/> <input type="checkbox"/> Cough Blood             |  |   |   |  |

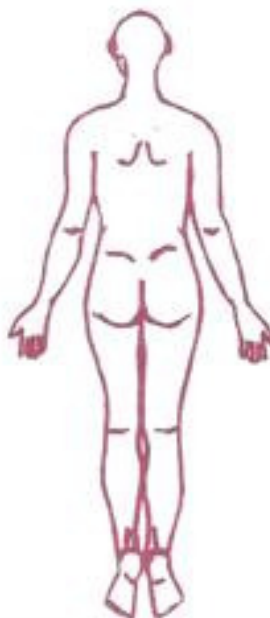
Have you or any bloodline family members ever had the following: (Mark "F" for family and "Y" for you)

- |  |  |  |  |  |
|--|--|--|--|--|
| F Y  | F Y  | F Y  | F Y  | F Y  |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes       | <input type="checkbox"/> <input type="checkbox"/> Asthma             | <input type="checkbox"/> <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> <input type="checkbox"/> Drug Addiction       | <input type="checkbox"/> <input type="checkbox"/> Pace Maker     |
| <input type="checkbox"/> <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> <input type="checkbox"/> Anemia             | <input type="checkbox"/> <input type="checkbox"/> German Measles     | <input type="checkbox"/> <input type="checkbox"/> HIV Positive         | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis   |
| <input type="checkbox"/> <input type="checkbox"/> Stroke         | <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> <input type="checkbox"/> Tumors               | <input type="checkbox"/> <input type="checkbox"/> Heart Disease  |
| <input type="checkbox"/> <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> <input type="checkbox"/> Congenital Disease | <input type="checkbox"/> <input type="checkbox"/> Allergies          | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease     | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> <input type="checkbox"/> Ruptures           | <input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> <input type="checkbox"/> Smoker         | <input type="checkbox"/> <input type="checkbox"/> Cancer             | <input type="checkbox"/> <input type="checkbox"/> Scarlet Fever      |  | <input type="checkbox"/> <input type="checkbox"/>                |

Mark all affected areas on the body with the appropriate symbols that describe your sensations.



- Numbness:      = =  
                          = =
- Pins and needles:    ○ ○  
                              ○ ○
- Aching:                X X X  
                              X X X
- Stabbing:             / / /  
                              / / /



Mark an "X" on the line below that best describes the intensity of your primary complaint.

- Neck:            LOW ----- HIGH
- Mid-Back:      LOW ----- HIGH
- Low Back:     LOW ----- HIGH
- Extremities:    LOW ----- HIGH

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

ADD  ACCOUNT#  
 CHG   
 DEL

**DEAR PATIENT:** Please assist us by clearly and correctly completing the information in the outlined areas. Do NOT write or mark in shaded areas.  
 Please give your insurance card(s) to the receptionist for copying.

<b>PATIENT</b>		FIRST NAME	MIDDLE INIT.	LAST NAME	ACCT. TYPE	
PATIENTS SEX <input type="checkbox"/> 1 MALE <input type="checkbox"/> 2 FEMALE	AGE	BIRTHDAY - -	SOCIAL SECURITY# - -	MARITAL STATUS <input type="checkbox"/> MR <input type="checkbox"/> MRS <input type="checkbox"/> DIV <input type="checkbox"/> WID	EMPLOYMENT <input type="checkbox"/> FULL <input type="checkbox"/> PART <input type="checkbox"/> RETI <input type="checkbox"/> UNEMP	STUDENT <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART <input type="checkbox"/> NOT STU
STREET ADDRESS			CITY		STATE ZIP CODE	
HOME TELEPHONE NUMBER ( ) -		EMPLOYER'S TELEPHONE NUMBER ( ) -		EMPLOYER'S NAME	JOB DESCRIPTION	
<b>BILL TO</b>		FIRST NAME (if different than patient)	MIDDLE INIT.	LAST NAME (if different than patient)	MAIL CODE ACCT. TYPE	
STREET ADDRESS (if different than patient)			CITY (if different than patient)		STATE ZIP CODE	
<b>PRIMARY COVERAGE</b>		CARRIER CD NO.	PRIMARY INSURANCE CO. NAME & ADDRESS			
EMPLOYER		PRIMARY INSURANCE CO. CERTIFICATE OR CONTACT #		INSURANCE GROUP NO. OF EMPLOYER		
SOCIAL SECURITY NO. OF POLICY OWNER - -	BIRTHDATE - -	PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER <input type="checkbox"/> DISABLE <input type="checkbox"/> 7				
POLICY HOLDER NAME						
<b>SECONDARY COVERAGE</b>		CARRIER CD NO.	PRIMARY INSURANCE CO. NAME & ADDRESS			
EMPLOYER		PRIMARY INSURANCE CO. CERTIFICATE OR CONTACT #		INSURANCE GROUP NO. OF EMPLOYER		
SOCIAL SECURITY NO. OF POLICY OWNER - -	BIRTHDATE - -	PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER <input type="checkbox"/> DISABLE <input type="checkbox"/> 7				
POLICY HOLDER NAME						

**AUTHORIZATION** THE ABOVE SUBSCRIBER HEREBY AUTHORIZES HIS/HER INSURANCE COMPANY TO ISSUE INDEMNITY CHECKS TO THE ABOVE LISTED MEDICAL PROVIDER FOR SERVICES PROVIDED.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician OR organization furnishing the services and authorize such physician OR organization to submit a claim to my insurance carrier OR Medicare for payment. I authorize any holder of medical or other information about me to release to insurance carriers OR the Health Care Financing Administration and its agents OR the Social Security Administration or its intermediaries OR any agency, group or person(s) necessary to secure payment any information needed for this or related Medicare claim. \* For and in consideration of services rendered and to be rendered by the above listed medical provider, I hereby guarantee payment of all charges incurred for this account. \* The patient or his / her representative recognizing the need for health care, consents to the above listed medical provider rendering services as ordered by the physicians, including medical or surgical treatment, laboratory procedures, X-ray examinations or other services rendered under the general and specific instructions of the physicians. \* I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_ X  
 PATIENT (PARENT/GUARDIAN IF MINOR)

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## HEALTH CARE AUTHORIZATION FORM

Patient's Name \_\_\_\_\_  
Patients SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

THE PATIENT IDENTIFIED ABOVE AUTHORIZES TRUE HEALTH CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING :

### SPECIFIC AUTHORIZATIONS

I give permission to True Health Chiropractic to use my address, phone number and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.

### (OPEN ROOM AUTHORIZATION \_ OPTIONAL)

I give True Health Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving True Health Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

### EXPIRATION

The Authorization shall expire on the following date: Perpetual

### RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of True Health Chiropractic. The written notice must contain the following information:

- Your name, Social Security number and date of birth;
- A clear statement of your intent to revoke this AUTHORIZATION;
- The date of your request; and
- Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by True Health Chiropractic for its own use/disclosure of PHI.  
*(Minimum necessary standards apply.)*

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, True Health Chiropractic will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

- \* A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU \* •

Print Name of Patient

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Personal Representative

Description of Representative's  
Authority To Act for Patient:

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

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

\_\_\_\_\_  
Date