Tankersley Chiropractic

2327 NW Federal Highway • Stuart, FL 34994
Phone: (772) 238-1777

CONFIDENTIAL PATIENT HEALTH HISTORY

(please fill out in legible writing)

Name _____

Address _____

City _____ State _____ Zip _____

Date of Birth: _____ Home /Cell Phone: _____

Email Address: _____

Primary Insurance Company: _____

Secondary Insurance Company: _____

Marital Status: Single Married Widow(er) Not Sure

Occupation: _____

Emergency Contact: _____ Phone: _____

Have you ever seen a Chiropractor before? Yes No

Whom may we thank for referring you to our office? _____

List any medications you are taking or please provide a list on your next visit: _____

_____

Authorization to treat:
I understand that no guarantees have been made concerning my recovery as every individual will respond to Chiropractic differently. I hereby authorize Tankersley Chiropractic and whomever they may designate as an assistant to administer therapies and take x-rays if needed. I have read and understand the office policy stated above and agree to accept responsibility as described.

I understand that my account is considered delinquent if over 90 days old and may be sent to an outside source for collection. I agree that if Tankersley Chiropractic initiates collection efforts to recover amounts owed on my account, then, in addition to amounts owed for the services rendered, I will pay any and all costs incurred by Tankersley Chiropractic in pursuing collection, including, but not limited to, reasonable attorney fees, and any court costs or other costs of litigation incurred in collecting my delinquent account.

Patient/Guardian Signature: _____ **Date:** _____

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Authorization to release insurance and treatment information

I hereby instruct and authorize my insurance company to release information concerning my coverage and benefits for both health/auto insurance and pay by check made out and mailed directly to: Tankersley Chiropractic, 2327 NW Federal Highway, Stuart Fl 34994.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, 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.

I authorize Tankersley Chiropractic to release and gather any or all my medical records as deemed necessary to/from other health care providers. I also authorize the release of records to my insurance company as requested to facilitate payment to Tankersley Chiropractic. I understand this office will take all necessary precautions to ensure my privacy. I have been given a copy of the HIPAA regulations for my review.

I have read and understand the office policy stated above and agree to accept responsibility as described.

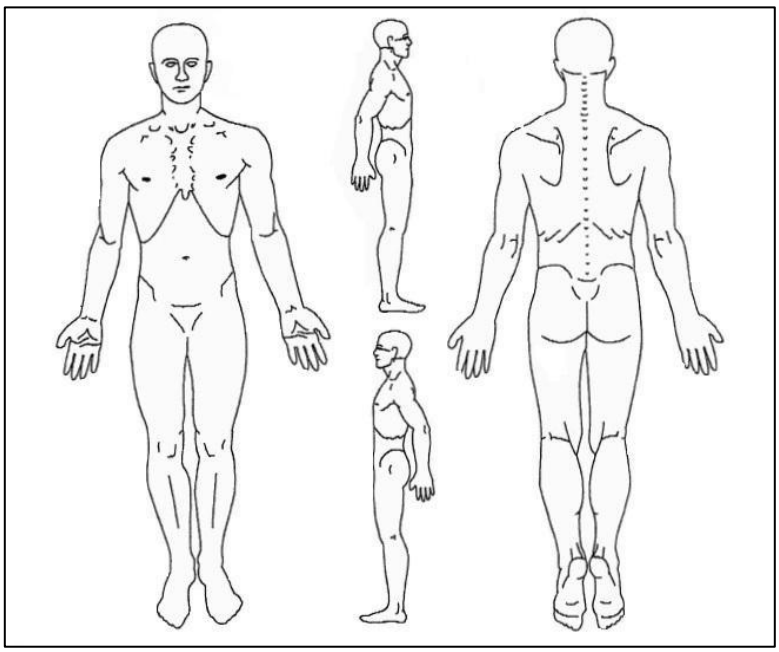
This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. By signing below, I acknowledge that I have been made aware of its availability.

Patient/Parent Signature: _____ **Date:** _____

Parent Name (printed) **:** _____

Pain Questionnaire

Name: _____ Date: _____



Mark all the areas of pain, stiffness and/or discomfort.

What is the #1 thing that bothers you the most today? _____

How does it feel? (circle all that apply): Sharp Stabbing Burning Achy Dull Stiff & Sore

How often does it hurt? Constant Off & On Daily Hourly Other: _____

Where does it radiate? Shoulder Arm/Hand Hip Leg/Foot Other: _____

What makes it feel better? Heat Ice Rest Movement Stretching Other: _____

What makes it feel worse? Sit Stand Walk Laying Sleep Work Other: _____

Overall, how would you rate your pain? 0 = no pain

At Its Best: 0 1 2 3 4 5 6 7 8 9 10 At Its Worse: 0 1 2 3 4 5 6 7 8 9 10

Other areas of pain/concern:

_____

_____

_____

Patient Review of Systems

Please check the corresponding boxes for each symptom or condition you have.

CERVICAL DYSFUNCTION

- ❑ Neck Pain/Stiffness
- ❑ Shoulder Pain/Stiffness
- ❑ Arms Pain
- ❑ Hand Pain
- ❑ Weakness Arm
- ❑ Weakness Hand
- ❑ Numbness/Tingling Arm
- ❑ Numbness/Tingling Hand
- ❑ Nervousness
- ❑ Depression
- ❑ Anxiety
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ Dizziness or Lightheaded
- ❑ Headaches
- ❑ Convulsions or Seizures

THORACIC DYSFUNCTION

- ❑ Middle Back Pain/Stiffness
- ❑ Flank Pain
- ❑ Rib Pain
- ❑ Reflux
- ❑ Difficulty Breathing
- ❑ Lung Problems
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain

LUMBAR/SACRAL DYSFUNCTION:

- ❑ Lower Back Pain/Stiffness
- ❑ Leg Pain
- ❑ Foot Pain
- ❑ Leg Numbness/Tingling
- ❑ Foot Numbness/Tingling
- ❑ Calf Cramps
- ❑ Painful Bowel Movements
- ❑ Diarrhea

LUMBAR/SACRAL DYSFUNCTION CONTINUED:

- ❑ Constipation
- ❑ Sexual Difficulty
- ❑ Frequent Urination
- ❑ Incontinence or Bed Wetting

GENERAL

- ❑ Recent Weight Change
- ❑ Fever
- ❑ Fatigue
- ❑ Condition worse with alcohol
- ❑ Tremors
- ❑ History of Stroke
- ❑ Chest Pains
- ❑ Heart Problems
- ❑ Blood Pressure Medication
- ❑ Ringing in the ears
- ❑ Autoimmunity Disease

TRAUMA

- ❑ Head Injury / Trauma
  Date: _____
- ❑ Auto Accident
  Date: _____
- ❑ Recent Broken Bones

Other Conditions / Trauma:

_____

_____

_____

_____

_____

_____

Name: _____ Date: _____