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: _____

Cell Carrier (AT&T, Verizon, T-Mobile) : _____

Email Address: _____

How would you like to receive appointment reminders? Email Text message None

Insurance Company: _____ Insured Name: _____

Marital Status: _____ Race/Ethnicity: _____

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 responds 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 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 insure 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.

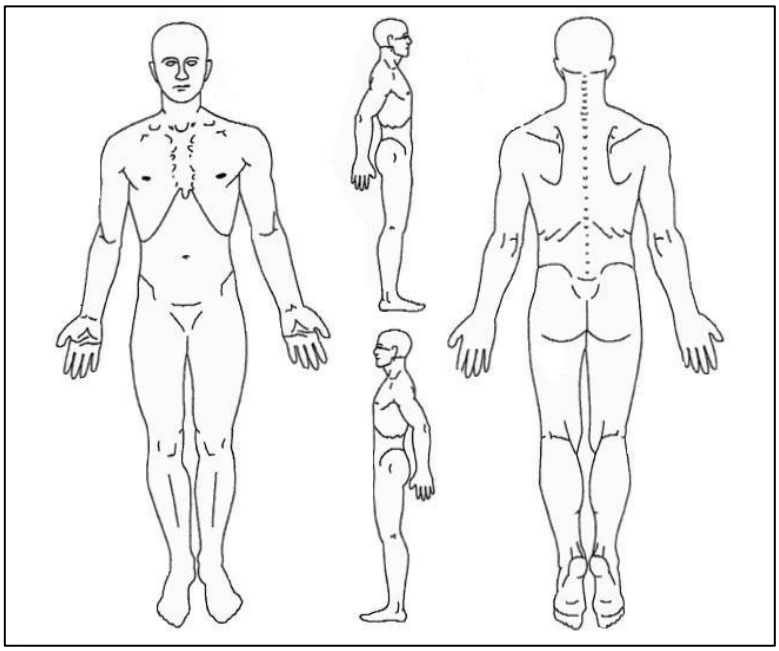
This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. By signing below, I acknowledge that I have been made aware of its availability.

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

Guardian Name (printed) **:** _____

Subjective Pain Questionnaire

Name: _____ Date: _____



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

What is your primary complaint? _____

Type of Pain (mark all that apply): Sharp Stabbing Burning Achy Dull Stiff & Sore

Frequency: ❑ Constant ❑ 0- 25% of the day ❑ 50- 75% of the day ❑ 75- 100% of the day

Where does it radiate (shoulder, arm, buttocks)? _____

What makes it feel better: _____

What makes it feel worse: _____

Overall, how would you rate your pain in the last few days:

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

What is your primary complaint? _____

Type of Pain (mark all that apply): Sharp Stabbing Burning Achy Dull Stiff & Sore

Frequency: ❑ Constant ❑ 0- 25% of the day ❑ 50- 75% of the day ❑ 75- 100% of the day

Where does it radiate (shoulder, arm, buttocks)? _____

What makes it feel better: _____

What makes it feel worse: _____

Overall, how would you rate your pain in the last few days:

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: _____

_____

_____

Name: _____ Date: _____

Many of the following conditions respond well to Chiropractic treatment. Please check all that apply or that you have experienced in the last 6-12 months.

General: (constitutional)
- ❑ Recent Weight Change
- ❑ Fever
- ❑ Fatigue
- ❑ ***None in this Category***

Musculoskeletal
- ❑ Neck Pain/Stiffness
- ❑ Middle Back Pain/Stiffness
- ❑ Lower Back Pain/Stiffness
- ❑ Shoulders Pain/Stiffness
- ❑ Arms Pain
- ❑ Hip Pain/Stiffness
- ❑ Leg Pain
- ❑ Muscle Spasms
- ❑ Calf Cramps
- ❑ Recent Broken Bones
- ❑ Other: _____
- ❑ ***None in this Category***

Neurological Have you ever had
- ❑ Numbness or tingling sensations
- ❑ Loss of Feeling
- ❑ Dizziness or Lightheaded
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or Seizures
- ❑ Tremors
- ❑ History of Stroke
- ❑ Head Injury / Trauma
- ❑ Auto Accident
- ❑ Date of last accident (any):
- ❑ Other: _____
- ❑ ***None in this Category***

Respiratory:
- ❑ Difficulty Breathing
- ❑ Asthma or Wheezing
- ❑ Lung Problems
- ❑ Other: _____
- ❑ ***None in this Category***

Mind/Stress:
- ❑ Nervousness
- ❑ Depression
- ❑ Anxiety
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ Other: _____
- ❑ ***None in this Category***

Genitourinary:
- ❑ Sexual Difficulty
- ❑ Frequent Urination
- ❑ Incontinence or Bed Wetting
- ❑ Other: _____
- ❑ ***None in this Category***

Gastrointestinal:
- ❑ Loss of Appetite
- ❑ Change in Bowel Movements
- ❑ Painful Bowel Movements
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Other: _____
- ❑ ***None in this Category***

Cardiovascular & Heart:
- ❑ Chest Pains
- ❑ Rapid or Heartbeat changes
- ❑ Blood Pressure Problems
- ❑ Swelling Hands, Ankles, Feet
- ❑ Heart Problems
- ❑ Other: _____
- ❑ ***None in this Category***

Eyes and Vision:
- ❑ Blurred or double vision
- ❑ Ocular Migraines (spots)
- ❑ Other: _____
- ❑ ***None in this Category***

Ears, Nose and Throat:
- ❑ Swollen glands in neck
- ❑ Ringing in the ears
- ❑ Earache / Ringing
- ❑ Ear Drainage
- ❑ Sinus / Allergy problems
- ❑ Hearing Loss
- ❑ Other: _____
- ❑ ***None in this Category***

Endocrine, Hematologic, and Lymphatic:
- ❑ Thyroid problems
- ❑ Cold Extremities
- ❑ Heat or Cold intolerance
- ❑ Swollen Glands
- ❑ Immune System Disorder
- ❑ Other:
- ❑ **None *in this Category***

Skin:
- ❑ Rash or Itching
- ❑ Change in Skin Color
- ❑ Change in hair or nails
- ❑ ***None in this Category***

Women Only:
- ❑ Painful or Irregular periods
- ❑ Other: _____
- ❑ ***None in this Category***