

PATIENT INFORMATION- Please Print

GENERAL INFORMATION

Patient Last Name _____ First Name _____
 Address _____ Care of _____
(Parent or financially responsible person)
 City _____ State _____ Zip Code _____ Phone (Home) _____
 Driver's License # _____ No. Children _____ Phone (Work) _____
 Email Address _____ Cell Phone _____

Sex	M	F	Married	Single	Widowed	Divorced	Age	Date of Birth	Social Security Number
								/ /	-- --
Employer's Name _____								EMPLOYED Full Time Part Time Not Employed Retired	
Address _____									
City _____ State _____ Zip Code _____								STUDENT Full Time Part Time Non-Student	
Phone _____ Occupation _____									
Spouse's Name _____ Spouse's Employer _____									
Spouse's Date of Birth _____									

REFERRED BY: _____

INSURANCE INFORMATION

Primary Insurance Company Name _____ Insured's Name _____ ID/Membership # _____ Policy/Group # _____ Customer Service Phone # _____	Secondary Insurance Company Name _____ Insured's Name _____ ID/Membership # _____ Policy/Group # _____ Customer Service Phone# _____
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Are you seeing the Doctor today due to a:

(If yes, please inform the front desk)

Work Related Injury? Yes _____ No _____ Date of Injury _____

Auto Accident? Yes _____ No _____ Date of Injury _____

RELEASE AND ASSIGNMENT

I agree to treatment by my doctor and such persons of the doctor's choosing, which may include interns, preceptors, Chiropractic assistants, etc and hereby provide my consent for treatment.

Patient's Signature _____ Date _____

I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to my chiropractor.

Patient's Signature _____ Date _____

I understand that Brennan Chiropractic will prepare any necessary forms to assist me in submitting claims to my insurance provider and credit my account when payment is received. However, I clearly understand that all services rendered to me are charged to me and I am responsible for payment unless other arrangements are made.

Patient's Signature _____ Date _____

PATIENT HISTORY/EXAMINATION FORM

Complete ALL Questions below

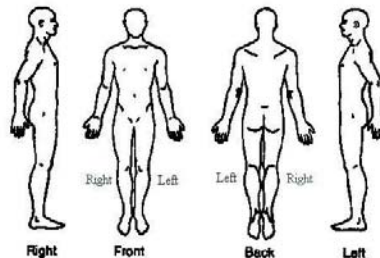
1. What are your **major** complaint(s)/ illnesses? _____
2. What are your **minor** complaint(s)/illnesses? _____
3. How **long** have you been experiencing your major complaint?
 Days Weeks Months Years

Mechanism of Injury

4. What was the **cause** of your major complaint (how did it happen)? _____
5. **When** did you first experience your major complaint? _____
6. What have you done **prior** to coming to this office to treat your major and minor complaints? _____
7. When do you **notice** your complaint(s) the most? AM PM BOTH
8. How long does it last? _____ Minutes _____ Hours
9. What makes it feel **worse**? Sitting Standing Lying Activity Other _____
10. What makes it feel **better**? Sitting Standing Lying Activity Drugs Other _____
11. What best describes the character and quality of your major illness or pain?
 A. ache B. burning pain T: tingling N: numbness S. sharp C: cramping D. dull pain
12. Have you had this problem in the past?

13. On the diagram below, please **show** where you are experiencing all of your present complaints using the following letters:

A. ache B. burning pain T: tingling N: numbness S. sharp C: cramping D. dull pain



14. On the scale below, please **circle** the severity and intensity of your main complaint (at its' worst):

None	Slight	Mild	Moderate	Severe					
1	2	3	4	5	6	7	8	9	10

15. On the scale below, please **circle** the percentage of time you experience of your major complaint:

Occasional	Intermittent	Frequent	Constant						
1	2	3	4	5	6	7	8	9	10

16. Does your pain radiate? Yes _____ No _____
 If yes, where does it radiate to? _____

Signature _____ **Date** _____

Patient History
 Please check (x) all present symptoms

<p>HEAD:</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Sinus</p> <p><input type="checkbox"/> Entire Head</p> <p><input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Forehead</p> <p><input type="checkbox"/> Temples</p> <p><input type="checkbox"/> Migraine</p> <p><input type="checkbox"/> Loss of Memory</p> <p><input type="checkbox"/> Light-headed</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Light bothers eyes</p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> Loss of vision</p> <p><input type="checkbox"/> Loss of balance</p> <p><input type="checkbox"/> Loss of taste</p> <p><input type="checkbox"/> Loss of hearing</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Pain in ears</p> <p><input type="checkbox"/> Ringing or noises in ears</p> <p>NECK:</p> <p><input type="checkbox"/> Pain in neck</p> <p><input type="checkbox"/> Sharp</p> <p><input type="checkbox"/> Dull</p> <p><input type="checkbox"/> Ache</p> <p><input type="checkbox"/> Neck pain with movement</p> <p><input type="checkbox"/> Forward</p> <p><input type="checkbox"/> Backward</p> <p><input type="checkbox"/> Turning (L) (R)</p> <p><input type="checkbox"/> Bending (L) (R)</p> <p><input type="checkbox"/> Pinched nerve in neck</p> <p><input type="checkbox"/> Neck feels out of place</p> <p><input type="checkbox"/> Muscle spasms in neck</p> <p><input type="checkbox"/> Grinding sounds in neck</p> <p><input type="checkbox"/> Popping sounds in neck</p> <p>SHOULDERS:</p> <p><input type="checkbox"/> Pain in joint (L) (R)</p> <p><input type="checkbox"/> Pain across shoulders</p> <p><input type="checkbox"/> Arthritis (L) (R)</p> <p><input type="checkbox"/> Can't raise arm</p> <p><input type="checkbox"/> Above Shoulder level</p> <p><input type="checkbox"/> Over head</p> <p><input type="checkbox"/> Tension in shoulders</p> <p><input type="checkbox"/> Pinched nerve in shoulder</p> <p><input type="checkbox"/> Muscle spasms in shoulder</p> <p>ARMS AND HANDS:</p> <p><input type="checkbox"/> Pain in arm</p> <p><input type="checkbox"/> Tennis elbow</p>	<p><input type="checkbox"/> Pain in hands/fingers (L) (R)</p> <p><input type="checkbox"/> Pins and needles sensation</p> <p><input type="checkbox"/> Numbness (L) (R)</p> <p><input type="checkbox"/> Hands cold</p> <p><input type="checkbox"/> Loss of grip strength</p> <p><input type="checkbox"/> Sore/swollen joints in fingers</p> <p>MIDBACK:</p> <p><input type="checkbox"/> Mid-back pain</p> <p><input type="checkbox"/> Pain between shoulder blades</p> <p><input type="checkbox"/> Sharp stabbing</p> <p><input type="checkbox"/> Dull ache</p> <p><input type="checkbox"/> Muscle Spasms</p> <p>CHEST:</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Rib pain</p> <p><input type="checkbox"/> Breast pain</p> <p><input type="checkbox"/> Irregular heartbeat</p> <p>ABDOMEN:</p> <p><input type="checkbox"/> Nervous stomach</p> <p><input type="checkbox"/> Foods cant eat _____</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Gas</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Hemorrhoids</p> <p>LOW BACK:</p> <p><input type="checkbox"/> Lower back pain</p> <p><input type="checkbox"/> Sharp</p> <p><input type="checkbox"/> Dull</p> <p><input type="checkbox"/> Ache</p> <p>Location:</p> <p><input type="checkbox"/> Upper lumbar</p> <p><input type="checkbox"/> Lower lumbar</p> <p><input type="checkbox"/> Hip</p> <p><input type="checkbox"/> Low back pain is worse when</p> <p><input type="checkbox"/> Working</p> <p><input type="checkbox"/> Lifting</p> <p><input type="checkbox"/> Stooping</p> <p><input type="checkbox"/> Standing</p> <p><input type="checkbox"/> Sitting</p> <p><input type="checkbox"/> Bending</p> <p><input type="checkbox"/> Coughing</p> <p><input type="checkbox"/> Lying Down</p> <p><input type="checkbox"/> Walking</p> <p>Pain relieved when _____</p> <p><input type="checkbox"/> Slipped Disc</p> <p><input type="checkbox"/> Low back feels out of place</p> <p><input type="checkbox"/> Muscle spasms</p>	<p>HIPS, LEGS, & FEET:</p> <p><input type="checkbox"/> Pain in buttocks</p> <p><input type="checkbox"/> Pain in hip joint</p> <p><input type="checkbox"/> Pain down leg</p> <p><input type="checkbox"/> Knee pain</p> <p><input type="checkbox"/> Outside</p> <p><input type="checkbox"/> Inside</p> <p><input type="checkbox"/> Leg cramps</p> <p><input type="checkbox"/> Feet cramps</p> <p><input type="checkbox"/> Pins and needles in legs</p> <p><input type="checkbox"/> Numbness in legs/feet</p> <p><input type="checkbox"/> Swelling in legs/feet</p> <p>WOMEN ONLY:</p> <p><input type="checkbox"/> Menstrual pain</p> <p><input type="checkbox"/> Cramping</p> <p><input type="checkbox"/> Irregularity</p> <p><input type="checkbox"/> Cycle _____ Days</p> <p><input type="checkbox"/> Birth Control _____ type</p> <p><input type="checkbox"/> Hysterectomy</p> <p><input type="checkbox"/> Tumors/Cancer</p> <p><input type="checkbox"/> Discharge</p> <p><input type="checkbox"/> Menopause</p> <p><input type="checkbox"/> Abortions</p> <p><input type="checkbox"/> Are you pregnant?</p> <p>MEN ONLY:</p> <p><input type="checkbox"/> Urinary frequency</p> <p><input type="checkbox"/> Difficult urination</p> <p><input type="checkbox"/> Night urination</p> <p><input type="checkbox"/> Prostate swelling</p> <p>GENERAL:</p> <p><input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> Irritable</p> <p><input type="checkbox"/> Depressed</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Run-down feeling</p> <p><input type="checkbox"/> Normal sleep _____ hrs</p> <p><input type="checkbox"/> Loss of sleep</p> <p><input type="checkbox"/> Loss of weight</p> <p><input type="checkbox"/> Weight Gain</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Hypoglycemia</p> <p><input type="checkbox"/> Cigarettes _____ pack/day</p> <p><input type="checkbox"/> Coffee _____ cups/day</p> <p>OTHER _____</p> <p>Medications _____</p> <p>_____</p>
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POLICIES

1. All first visit charges are payable when services are rendered.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. One films are used for treatment purposes, they cannot be released. Copies can be made if necessary.
3. Method of payment you plan to use to take care of today's charges?

Cash Check Visa/Mastercard

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Brennan Chiropractic Center will prepare any necessary reports and forms to assist in making collections from the insurance company and that nay amount authorized to be paid directly to Brennan Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all my services are charged directly to me and that I am responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect on this account. If an account balance remains unpaid for three months or longer, a monthly interest fee of 2% will apply to the account balance. I authorize Brennan Chiropractic to obtain a credit report if deemed necessary.

Patient Signature _____ Date _____

Guardian Signature Authorizing Care _____ Date _____

In case of emergency, please notify _____

Relationship _____

Address _____

Phone # _____

Patient Privacy Notice

This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

In the course of your care at Brennan Chiropractic we may use or disclose personal and health related information about you in the following ways:

Your personal health information, including your clinical records, may be disclosed to another health provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment. Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or an employer, if they are or may be responsible for the payment of your services. Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further you have the right to impact or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you of the reimbursement avenues associated with your care.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form please advise us in writing as to your preferences.

Under federal law, we are also permitted or required to use or disclose your information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the order from another provider.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communication with you, but in our professional judgment we believe you intend for us to provide care.
- If we are ordered by the appropriate agency.

Any use or disclosure of your protected health information other than outlines above will only be made with your written authorization.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health information must be provided to us in writing.

We are required by state and federal law to maintain the privacy of your file and the protected health information therein. We are also required to provide you with this notice of our privacy practices.

We are further required by law to abide by the terms of this notice while it is effect. We reserve the right to altar or amend the terms of this notice. If changes are made to our privacy policy we will notify you in writing. Any change in our privacy notice will apply to all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by federal privacy rules.

If you have a complaint regarding our privacy policy, our privacy practices you should direct your complaint to the Privacy Officer at 351 Wellesley Trade Lane, Suite 101, Cary NC, 27519.

This office utilizes an 'open treatment' environment for ongoing patient care. "Open treatment" involves the possibility of our patients being seen in the same treatment environment at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within hearing of other patients and staff. A private, closed and confidential setting is provided for history taking, examinations, report of findings, etc. as determined by the doctor or staff. The use of this format is to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and information. If you choose not to be adjusted or use traction in an 'open treatment' environment, other arrangements will be made for you. This office also requests the presence of your spouse or significant other at your Doctor's Report appointment for the purpose of health education.

This notice is effective as of January 20, 2004. This notice and any alterations made hereto will expire seven years after this date. My signature acknowledges that I have received a copy of this notice.

Signature _____ Printed Name _____ Date _____

HEALTH HISTORY OF FAMILY MEMBERS

The reason for this form is to assist the doctor by providing past health history information for their review

Condition	Self	Father	Mother	Spouse	Brothers	Sisters	Children
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Disc Problems							
Drinker							
Drug Addiction							
Emphysema							
Epilepsy							
Headaches							
Heart Trouble							
High Blood Pressure							
Kidney Trouble							
Migraine							
Nervousness							
Neuritis							
Neuralgia							
Pinched Nerve							
Scoliosis							
Sinus Trouble							
Smoker							
Stomach Trouble							