WOOD CHIROPRACTIC
SCOTT WOOD D.C. | JAY EAST D.C.
232 STATE STREET | GARNER, IA
641-923-2059

Patient Health History

Today's Date _____ **Signature of Patient** _____

First Name _____ **Nick Name** _____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Cell Phone _____ **Land Line** _____

Email _____

By providing my email address, I authorize my doctor to contact me via the email address provided.

***Security question: What is your favorite color?** _____

Briefly list your main health problems and *CHIEF COMPLAINT*: _____

_____

Date of Birth _____ **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Emergency Contact _____ **Phone#** _____

Spouse's Name _____ **Phone #** _____

Your Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Employer _____ **Ph #** _____

***IS THIS A WORKER'S COMP CLAIM OR CAR ACCIDENT CLAIM?* ❑ YES ❑ NO**

(IF "YES", PLEASE NOTIFY THE FRONT DESK AT THIS TIME)

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑Other_____ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ Other_____ ❑ I choose not to specify

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

How long have you smoked?_____yrs

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

Current medications, including dosage and frequency, if known.

If there are no current medications, check here: ☐

		Dosage	How Often?		Dosage	How Often?
1)				**6)**		
2)				**7)**		
3)				**8)**		
4)				**9)**		
5)				**10)**		

List any known *medication* allergies. **If no known medication allergies, check here: ❑**

1) _____ **3)** _____

2) _____ **4)** _____

Has any doctor diagnosed you with *Hypertension* presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with *Diabetes* presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had back surgery? ❑ Yes ❑ No

Please Explain_____

Have you sought treatment elsewhere for this condition? ❑ YES ❑ NO

If "YES", where?_____

What treatment did you receive?_____

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 3 months? ❑ Yes ❑ No

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____

INSURANCE INFORMATION: (please provide card)

Would you like your insurance filed? ❑ Yes ❑ No

NAME OF PRIMARY INSURANCE HOLDER_____ **DOB**_____/_____/_____

YOUR RELATIONSHIP TO INSURANCE HOLDER: ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER _____

PRIMARY INSURANCE _____

POLICY #_____ **GROUP #**_____

SECONDARY INSURANCE (if Primary = Medicare)_____

POLICY#_____ **GROUP #**_____

Guarantor (Person Responsible for account payment)

NAME _____**DATE OF BIRTH**_____/_____/_____

GENDER: ❑ MALE ❑ FEMALE

ADDRESS_____**CITY**_____**ZIP**_____

PHONE_____

****

WERE YOU REFERRED HERE? ❑ YES ❑ NO WHO REFERRED YOU?_____

How did you hear about Wood Chiropractic Clinic? ❑ Friend/Family ❑ Facebook ❑ Internet
❑ Avery Theater ❑ Newspaper ❑ Radio ❑ Phone book ❑ Other _____

HAVE YOU EVER BEEN TO A CHIROPRACTOR BEFORE? YES / NO

CLINIC/DOCTOR'S NAME? _____

DO YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING?

___HEADACHE	**___ALLERGIES**	**___NUMBNESS OR PAIN?**
___CONSTIPATION	**___DIARRHEA**	**WHERE? _____**
___HEART	**___STROKES**	**___HIGH BLOOD PRESSURE**
___SKIN	**___RESPIRATORY**	**___EYE PROBLEMS**
___URINARY	**___BOWEL CONTROL**	**___ARTHRITIS**

___OTHER _____

WOMEN ONLY

___PREGNANT AT THIS TIME		**___PAINFUL PERIODS**
___PMS	**___CRAMPS/BACKACHE**	**___OTHER**_____

Patient's Written Acknowledgment:

(Please initial each statement and sign at the bottom)

Notice of Privacy Practices:

I, acknowledge that I was given an opportunity to read Wood Chiropractic Clinic's Notice of Privacy Practices and was provided a copy if requested. I fully understand them and have had all my questions answered to my satisfaction. X _____
(Initials)

Statement of Informed Consent

Chiropractic adjustments are performed in our office by a skilled doctor of chiropractic who has successfully completed advanced educational requirements, national board examinations, and state board examinations. Our doctors and staff make every effort possible to provide the safest chiropractic care. Due to the nature of all health care delivery systems, some inherent risk exists. Whenever possible, this risk is minimized to its lowest level. Recent studies have shown risk of serious injury to be less than 1 in every 5.85 million adjustments. Still other research suggests that any connection between serious injury and chiropractic adjustments is purely coincidental. I have read and understand the above statement and have had any of my concerns answered to my satisfaction. X_____
(Initials)

Assignment of Benefits/Responsibility of Charges

(Authorization to file charges directly to your insurance company)

I, authorize Wood Chiropractic Clinic, PC to submit my insurance claims to my insurance company. By having my signature on file, I need not sign each claim submitted by their office. I understand that I may withdraw my signature at any time. I understand that I am ultimately responsible for all charges for which my insurance company does not pay.

I also understand that I am responsible for any charges necessary to collect fees owed to Wood Chiropractic Clinic, PC.

Patient _____ Date_____
(Printed Name)

X_____ X_____
(Signature) (Signature of Parent/Guardian, if applicable)