**DATE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRES**S\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CITY**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**STATE**\_\_\_\_\_\_\_**ZIP**\_\_\_\_\_\_\_\_\_\_\_\_

**CELL PHONE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOME PHONE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMAIL**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENDER**\_\_\_\_\_\_\_\_\_\_\_**AGE**\_\_\_\_\_\_\_\_\_\_\_\_**BIRTHDATE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MARRIED**\_\_\_\_\_\_\_\_\_\_\_\_\_**DIVORCED\_\_\_\_\_\_**\_\_\_\_\_\_\_**SINGLE\_\_\_\_\_**\_\_\_\_\_\_\_\_\_

**MINOR**\_\_\_\_\_\_\_\_\_\_\_\_\_\_**SEPARATED**\_\_\_\_\_\_\_\_\_\_\_\_**WIDOWED**\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL SECURITY NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WHOM MAY WE THANK FOR REFERRING YOU?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OCCUPATION**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT EMPLOYER/SCHOOL**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT PERSON**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELATIONSHIP**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PHONE NUMBER**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDITIONAL QUESTIONS**

**IS YOUR CONDITION CAUSED BY AN ACCIDENT?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ARE YOU PREGNANT? \_\_\_\_\_\_\_\_\_\_\_\_DUE DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE GIVE PHOTO ID AND INSURANCE CARD TO RECEPTION FOR COPIES**

**INSURANCE**

**WHO IS RESPONSIBLE FOR ACCOUNT**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELATIONSHIP TO PATIENT**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**POLICY HOLDER’S BIRTHDATE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE CO.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IS PATIENT COVERED BY ADDITIONAL INS?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF YES,**

**POLICY HOLDER NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELATIONSHIP TO PATIENT**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**POLICY HOLDER’S BIRTHDATE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE CO**.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ASSIGNMENT AND RELEASE

I certify that I, and or my dependent(s) have insurance coverage with the insurance company(ies) listed above, and assign directly to Dr. Brandon Jackson or Dr. Garrett Jackson, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I authorize the use of my signature on all insurance submissions. True Health Chiropractic may use my healthcare information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent is valid for up to 7 years after the date signed below and/or until I change insurance policies.

Signature of patient, parent, guardian, or representative

Print name of the above signed

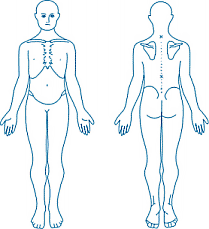
PATIENT HEALTH HISTORY/MEDICAL CONDITIONS

**REASON FOR VISIT:**

**WHEN DID SYMPTOMS FIRST APPEAR?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IS IT PROGRESSIVELY GETTING WORSE?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**RATE THE SEVERITY OF YOUR PAIN:** 1 **(*BEING LEAST)* -** 10 ***(BEING WORST)****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***MARK AN X ON THE PICTURE WHERE YOU CONTINUE TO HAVE TINGLING, NUMBNESS, OR PAIN***



**TYPE OF PAIN: *MARK X ON ALL THAT APPLY***

**NUMBNESS\_\_\_\_\_\_\_\_\_TINGLING\_\_\_\_\_\_\_\_\_ACHING\_\_\_\_\_\_\_\_\_\_STABBING\_\_\_\_\_\_\_\_\_**

**SHARP\_\_\_\_\_\_\_\_DULL\_\_\_\_\_\_\_\_SHOOTING\_\_\_\_\_\_\_THROBBING\_\_\_\_\_\_\_CRAMPS\_\_\_\_\_**

**STIFFNESS\_\_\_\_\_\_SWELLING\_\_\_\_\_\_\_BURNING\_\_\_\_\_\_\_OTHER\_\_\_\_\_\_\_\_\_**

**HOW OFTEN DO YOU HAVE THIS PAIN: *(CIRCLE ONE)***

**CONSTANT FREQUENT OCCASIONAL RARELY COMES AND GOES**

**DOES IT INTERFERE WITH: *(YES OR NO)***

**WORK\_\_\_\_\_\_\_\_ACTIVITY\_\_\_\_\_\_\_SLEEP\_\_\_\_\_\_\_\_**

**ACTIVITIES OR MOVEMENTS THAT ARE DIFFICULT TO PERFORM: (YES OR NO)**

**SITTING\_\_\_\_\_\_STANDING\_\_\_\_\_\_BENDING\_\_\_\_\_LYING DOWN\_\_\_\_\_WALKING\_\_\_\_**

**WHAT TREATMENT HAVE YOU ALREADY HAD FOR THIS CONDITION?**

**PRIMARY CARE DOCTOR’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY CARE DOCTOR’S LOCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF LAST: PHYSICAL\_\_\_\_\_\_\_\_\_\_X-RAY\_\_\_\_\_\_\_\_\_\_\_\_**

**ANY OTHER TESTS DONE, PLEASE DESCRIBE AND LIST DATE: *(MONTH/YEAR)***

**CHECK ALL THAT YOU PRESENTLY OR PREVIOUSLY DEALT WITH:**

**AIDS/HIV\_\_\_\_\_ALCOHOLSIM\_\_\_\_\_ALLERGIES\_\_\_\_\_ANOREXIA\_\_\_\_\_ARTHRITIS\_\_\_\_**

**ASTHMA\_\_\_\_\_BREAST LUMP\_\_\_\_\_BRONCHITIS\_\_\_\_\_BULIMIA\_\_\_\_\_CANCER\_\_\_\_\_\_**

**CHICKEN POX\_\_\_\_\_DIABETES\_\_\_\_\_EMPHYSEMA\_\_\_\_\_EPILEPSY\_\_\_\_\_GOITER\_\_\_\_\_\_**

**GONORRHEA\_\_\_\_\_GOUT\_\_\_\_\_HEART DISEASE\_\_\_\_\_HEPATITIS\_\_\_\_\_HERNIA\_\_\_\_\_\_**

**HERNIATED DISC\_\_\_\_\_HERPES\_\_\_\_\_HIGH CHOLESTEROL\_\_\_\_\_**

**HIGH BLOOD PRESSURE\_\_\_\_\_\_KIDNEY DISEASE\_\_\_\_\_\_\_**

**LIVER DISEASE\_\_\_\_\_MIGRAINES\_\_\_\_\_\_MISCARRIAGE\_\_\_\_\_MONONUCLEOSIS\_\_\_\_\_**

**MS\_\_\_\_\_OSTEOPOROSIS\_\_\_\_\_PACEMAKER\_\_\_\_\_PARKINSON’S\_\_\_\_PNEUMONIA\_\_\_\_**

**PROSTATE PROBLEM\_\_\_\_\_\_PSYCHIATRIC CARE\_\_\_\_\_\_RA\_\_\_\_\_STROKE\_\_\_\_**

**SLEEP APNEA\_\_\_\_\_THYROID\_\_\_\_\_TONSILITIS\_\_\_\_\_TB\_\_\_\_\_TUMORS/GROWTHS\_\_\_\_\_**

**ULCERS\_\_\_\_VENEREAL DISEASE\_\_\_\_\_ OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CIRCLE ALL THAT APPLY:**

***EXERCISE*: INTENSE MODERATE OCCASIONAL NONE**

***WORK*: SITTING STANDING LIGHT LABOR HEAVY LABOR**

***HABITS*: SMOKING ALCOHOL CAFFEINE HIGH STRESS LEVEL**

**INJURIES/SURGERIES**

**FALLS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HEAD TRAUMA\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FRACTURES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DISLOCATIONS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SURGERIES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATIONS/VITAMINS/SUPPLEMENTS:**

**Patient Acknowledgement and Receipt of**

**Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Patient’s Name

The undersigned does hereby acknowledge that he or she has signed this office’s Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office’s HIPAA Compliance Manual is available upon request and is located on this office’s website, StayTrueChiro.com.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Noti**c**e of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature

If patient is a minor or under a guardianship order as defined by State law:

By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian (circle one)