Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] HOME [ ] WORK

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Married\_\_\_\_\_\_\_\_\_\_\_\_\_ Divorced\_\_\_\_\_\_\_\_\_\_\_\_\_ Single\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Minor\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Separated\_\_\_\_\_\_\_\_\_\_\_\_ Widowed\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDITIONAL QUESTIONS**

Is your condition caused by an accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? \_\_\_\_\_\_\_\_\_\_\_\_ Due Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a heart device of any kind? YES NO

If yes, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you active military or a veteran? YES NO

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

Primary Care Doctor Name (if applicable)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Doctor’s location:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Approximate Date of last Physical: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What imaging (x-rays, MRI’s, etc.) have you had within the last year?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do we have permission to contact the patient’s Primary Care Provider to discuss any medical concerns that will affect their Chiropractic care?

[ ] Yes [ ] No

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of patient, parent, guardian, or representative

**ASSIGNMENT AND RELEASE**

I certify that I, and or my dependent(s), have insurance coverage with the insurance company/companies as cards were provided, and assign directly to 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 said insurance company/companies 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 your visit:

How long have your symptoms been present?

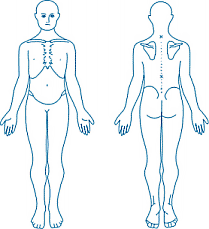
**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Is it getting progressively worse? \_\_\_\_\_\_\_\_\_\_ **Rate the severity of your pain:** 1 (*BEING LEAST)* - 10 *(BEING WORST) \_\_\_\_\_\_\_\_\_\_\_\_*

What treatment have you already had for this condition?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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



**Type of pain: (mark an X on all that apply)**

NUMBNESS\_\_\_\_\_\_\_ TINGLING\_\_\_\_\_\_\_ ACHING\_\_\_\_\_\_\_ STABBING\_\_\_\_\_\_\_

SHARP\_\_\_\_\_\_ DULL\_\_\_\_\_\_ SHOOTING\_\_\_\_\_\_ THROBBING\_\_\_\_\_\_ CRAMPS\_\_\_\_\_\_

STIFFNESS/TIGHTNESS\_\_\_\_\_\_ SWELLING\_\_\_\_\_\_\_ BURNING\_\_\_\_\_\_\_ OTHER\_\_\_\_\_\_\_\_\_

**How often do you have this pain? (Circle one)**

CONSTANT FREQUENT OCCASIONAL RARELY COMES AND GOES

**Does it interfere with:**

WORK\_\_\_\_\_\_\_ ACTIVITY\_\_\_\_\_\_\_ SLEEP\_\_\_\_\_\_\_\_ HOBBIES\_\_\_\_\_\_\_\_

**Activities or Movements that are difficult to perform:**

SITTING\_\_\_\_\_ STANDING\_\_\_\_\_ BENDING\_\_\_\_\_ LYING DOWN\_\_\_\_\_ WALKING\_\_\_\_\_

***MEDICAL HISTORY***

**Circle all that you presently have or previously have dealt with:**

AIDS/HIV ALCOHOLSIM ALLERGIES ANEURYSM 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 for your daily routine:**

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

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

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

**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 Name

The undersigned does hereby acknowledge that he or she has signed this office’s Notice of Privacy Practices Pursuant to HIPAA and is aware that a full copy of the HIPAA Compliance Manual is available upon request.

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 Signature

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

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

Signature of Parent/Guardian (circle one)