Basic Information

Today's Date:_____/_____/_____

Full Name: _____ **Employer:**_____

Preferred Name: _____ Occupation:_____

Current Address: _____ How Long have you worked there? _____

_____ Primary Care Physician's Name:

Date of Birth: _____/_____/_____ _____

Home Phone: (_____)_____ How did you hear about us?

Cell Phone: (_____)_____ _____

Email: _____

(Circle One) Male Female

Marital Status: Single Married Divorced Legally Separated Widowed

What main reason brings you in to us today? _____

_____

Current Physical Health

What are your major concerns about your health? (List them)

_____ _____ _____

_____ _____ _____

How are these health conditions/concerns affecting your life? _____

_____

How long has it been since you have really felt good? _____

Goals and Expectations

If you could change one thing about your physical health what would it be? _____

_____

And your nutritional (chemical) health? _____

What are your wellness goals/expectations that you would like to accomplish? _____

_____

Chemical (Nutritional) Health

List all medications, including dosage, and how long you have been taking them:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all vitamins and/or supplements:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How many bowel movements do you have per day/week? _____

Check the answer that best describes the following:

Typical color of your urine:

Light Yellow _____
Yellow _____
Orange _____
Red _____
Brown _____
Green _____

Typical clarity of your urine:

Clear _____
Slightly Cloudy _____
Very Cloudy _____
Mucousy _____
Bloody _____

Health History

List all major injuries and/or surgeries you have ever had with approximate dates:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Check any of the conditions that apply to you:

__Acne
__Alcohol/drug abuse
__Anemia
__Arthritis
__Artificial bones/joints
__Artificial valves
__Asthma
__Cancer
__Chemotherapy
__Chronic bad breath
__Congenital heart defect
__Depression
__Diabetes
__Difficulty breathing
__Emphysema/COPD
__Fainting/seizures
__Frequent neck/back
__Gingivitis
__Glaucoma
__Headache
__Heart attack/stroke
__Heart Murmur
__Hepatitis
__High Blood Pressure
__HIV / AIDS
__Low Blood Pressure
__Lyme Disease
__Mood Swings
__Pacemaker
__pain
__Psychiatric Disorder
__Severe/frequent
__Shingles
__Sinus Problems
__Skin Condition
__Tuberculosis
__Ulcers/Colitis
__Venereal Disease
Other:_____
_____
_____
_____
_____
_____
_____

List any family members who have experienced the same conditions as you:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Lifestyle

Check the answer that best describes the following:

Exercise	**Work Activities**	**Stress Level**
____None	____Mostly Sitting	____None
____Moderate	____Mostly Standing	____Low
____Daily	____Light Labor	____Moderate
____Heavy	____Heavy Labor	____High

Check any that apply:
Do you: ____Smoke ____Drink Alcohol ____Use Recreational Drugs ____Not Applicable

If so how often:_____

Patient Acknowledgement

I, _____, hereby declare that all the information I provided is true and current to the best of my knowledge.

I recognize Bent Chiropractic's ability to provide the best chiropractic care possible and give them permission to advise and treat me accordingly as well as to obtain payment for the treatment in order to carry out its health care operations.

I also acknowledge that Bent Chiropractic will keep all my information private according to the required Health Insurance Portability and Accountability Act (HIPPA).

By signing below, I acknowledge that I have read and understand the foregoing notice and all of my questions have been answered to my full satisfaction in a way that I understand it.

Print Patient's Name: _____

*Signature of Patient -or-Guardian:*_____

_____

(If Guardian Signed Please Print Name and Relationship to Patient Above)

Today's Date _____/_____/_____

(Relationship to patient)

X-ray Consent Form

I,_____, hereby authorize the performance of diagnostic x-rays. Dr. Amber Bent/ Dr. Matt Herrin has requested the x-rays for further diagnostic purposes. At this time, I know of no other condition which the taking of x-rays would further complicate.

Females: Regarding Possibility of Pregnancy:

This is to certify that I, _____, to the best of my knowledge, am NOT pregnant. The doctor and certified staff of Bent Chiropractic have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

By signing below, I acknowledge that I have read, understand, and agree to the above provisions.

Print Patient's Name: _____

Signature of Patient -or-Guardian:_____

_____

(If Guardian Signed Please Print Name and Relationship to Patient Above)

Today's Date _____/_____/_____

Patient Payment / NO Show Policy

We at Bent Chiropractic welcome you and look forward to providing you and your family with quality chiropractic care!

As our patient we ask for full agreement and understanding of our Billing, Appointment, and Patient Responsibilities policies listed below. Acknowledgment and acceptance of these policies are expected, and we thank you for your full cooperation. Happy health journey!

Patient Responsibilities and Billing Policy:

As a patient seeking services from bent Chiropractic it is your responsibility to:

- Make payment in full for all services rendered the day of your appointment
- Follow the time frame policies of any prepay package plans when purchased
- Follow and actively participate in the recommendations and care plans provided
- Keep all scheduled appointments and/or cancel any appointments 24 hours prior

Missed Appointment/ NO SHOW Policy:

You may be subject to a **Missed Appointment/ No Show Fee** of **$40.00** for any missed appointment. An appointment is considered a Missed Appointment/No Show if:

- You are a **No Show/No Call** for any scheduled appointment
- We do not receive a **24-hour notice for cancellation of an appointment**
- We do not receive a **1-hour notice for cancellation of same-day sick appointments**
- Late arrival for an appointment resulting in an appointment reschedule
- 2 missed appointments/no shows will result in possible termination from the practice

Patient acknowledgement and agreement of above policies:

Print Patient's Name: _____

Signature of Patient -or-Guardian:_____

_____

(If Guardian Signed Please Print Name and Relationship to Patient Above)

Today's Date _____/_____/_____