Today's Date:_____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date:____-____-____ Age: _____ Gender: _____

Address:_____City:_____State:_____Zip:_____

E-mail Address: _____ Mobile Phone_____ Work Phone _____

Marital Status: ☐ Single ☐ Married ☐ Widowed Spouse's Name _____

Driver's License #_____ Number of Children and Ages: _____

Employer: _____

Name & Number of Emergency Contact:_____ Relationship:_____

INSURANCE INFORMATION

While health insurance is designed to protect you in the event of a costly, major illness or injury, health insurance companies DO NOT PAY FOR unlimited chiropractic care. NO INSURANCE COMPANY WILL PAY FOR CORRECTIVE, REHABILITATIVE OR MAINTENANCE CHIROPRACTIC CARE. O'Dell Family Chiropractic will, to the best of our ability, verify your insurance and provide you with an estimation of your out-of-pocket cost. If the cost of chiropractic care is not a covered benefit we will provide you with an estimate of cost.

Please provide your insurance information below:

Name of Insurance Company: _____Insured's Date of Birth: _____

Identification #: _____ Group #: _____

Policy Holder's Name and Date of Birth: _____ Relationship: _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment to be made directly to O'Dell Family Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral source. Additionally, I authorize the release of any information required to secure payment for services rendered. I also authorize and direct that any insurance or medical coverage benefit payments to which I may be entitled shall be paid directly to O'Dell Family Chiropractic. I understand and agree that I am financially responsible for and will promptly pay any non-covered services, copays and deductible amounts. The patient understands and agrees to allow O'Dell Family Chiropractic to use their Patient Health information for the purpose of treatment, payment, healthcare operations and coordination of care.

Signature: _____Date: _____

TERMS OF AGREEMENT

OUR GOAL IS TO CORRECT VERTEBRAL SUBLUXATIONS, WHICH ALLOWS FOR A BETTER EXPRESSION OF HEALTH. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art and does not proclaim to cure or correct any named disease. We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. By signing below, I agree to the treatment recommended by my chiropractor. I intend this consent form to cover the entire course of treatment for my present condition(s)for which I seek treatment at this facility. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstance.

Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I understand that I have a right to review O'Dell Family Chiropractic's Notice of Privacy Practices prior to signing this document. The document describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of O'Dell Family Chiropractic. The Notice of Privacy Practices will be also provided on request at the front desk of this practice. The document describes my rights and O'Dell Family Chiropractic's duties with respect to my protected health information. O'Dell Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, ask for one at time of my next appointment, or accessing O'Dell Family Chiropractic's website. I have the right to revoke this consent, in writing, except to the extent that O'Dell Family Chiropractic has taken action in reliance on this consent.

Signature: _____ **Date:** _____

Name _____ Date_____

Please describe your MAJOR complaint/Why are you here?:

_____

_____

_____

When did your problem begin? _____ Previous History of this? Yes No When?_____

How did it begin?

_____

_____

_____

The pain ☐ is constant ☐ comes and goes. If it comes and goes, how often does the pain exist?

_____

Does it interfere with your ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Other_____

Activities or movements that are painful to perform:

☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐None ☐Other_____

What makes it better? _____

Have you seen another healthcare practitioner for the pain/condition? Yes No

If yes, who? _____

On the diagram below indicate the type of symptoms you are experiencing right now. Use corresponding symbols.

Pain Diagram and Rating

Please number and mark the severity of pain you are currently experiencing on a scale from 0 (no pain) to 10 (severe pain).

- Current pain: /10 0 1 2 3 4 5 6 7 8 9 10
- Average pain: /10 0 1 2 3 4 5 6 7 8 9 10

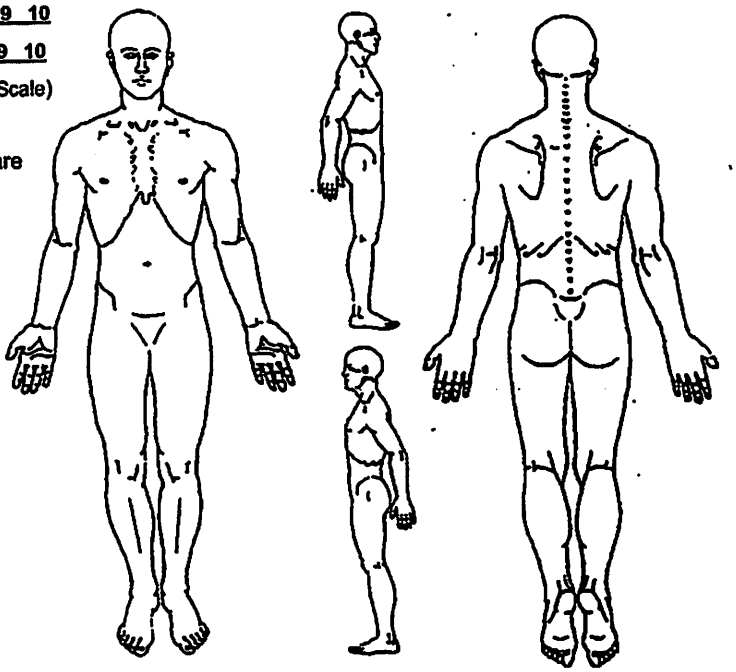
(Visual Analog Pain Severity Scale)

Please describe the type of pain or sensation you are currently experiencing. (Check all that apply)

☐ Aching A
☐ Burning B
☐ Dull D
☐ Numb N
☐ Sharp S
☐ Shooting
☐ Stabbing
☐ Stiffness
☐ Throbbing
☐ Tingling
☐ Other, describe it: _____

Comments:

Please mark on the diagram the location of the pain.



Current Height_____

Weight_____

Birth Date: _____ Age: _____

Referred by:_____

Previous chiropractic?_____ Last visit?_____

Review of Systems/Health History

(Indicate if you have these conditions Now or if you've had them in the Past)

Constitutional
- ◻ Fainting
- ◻ Fatigue/Low Energy
- ◻ Fever/Chills
- ◻ Loss of Appetite

Musculoskeletal
- ◻ Arthritis
- ◻ Gout
- ◻ Joint Replacement location: _____
- ◻ Joint Stiffness
- ◻ Muscle Weakness
- ◻ Osteoporosis
- ◻ Scoliosis

Cardiovascular
- ◻ Aortic Aneurysm
- ◻ Arteriosclerosis
- ◻ Chest Pain
- ◻ Congestive Heart Failure
- ◻ Coronary Artery Disease
- ◻ Heart Attack
- ◻ High Blood Pressure
- ◻ High Cholesterol
- ◻ Irregular Heartbeat
- ◻ Pacemaker
- ◻ Stroke

Endocrine
- ◻ Diabetes
- ◻ Thyroid Disorder

Other: _____

Respiratory
- ◻ Allergies
- ◻ Asthma
- ◻ COPD
- ◻ Emphysema
- ◻ Frequent Cold or Flu
- ◻ Pneumonia
- ◻ Sleep Apnea
- ◻ Tuberculosis

Digestive
- ◻ Constipation
- ◻ Diarrhea
- ◻ Food Sensitivities
- ◻ Gallbladder Issues
- ◻ Heartburn/Acid Reflux
- ◻ Liver Problems
- ◻ Nausea/Vomiting
- ◻ Ulcer

Neurological
- ◻ Brain Aneurysm
- ◻ Epilepsy/Seizures
- ◻ Head Injury
- ◻ Headaches/Migraines
- ◻ Multiple Sclerosis

Psychiatric
- ◻ Anxiety Disorders
- ◻ Depression
- ◻ Insomnia
- ◻ Unusual Stress

Genitourinary
- ◻ Burning with Urination
- ◻ Frequent Urination
- ◻ Kidney Disease
- ◻ Kidney Stones
- ◻ Sexually Transmitted Disease

Hematologic/Lymphatic
- ◻ Anemia
- ◻ Bleeding Disorders
- ◻ Blood Clot/DVT
- ◻ Cancer type: _____
- ◻ Excessive Bruising
- ◻ Hepatitis
- ◻ HIV/AIDS

Skin
- ◻ Acne
- ◻ Eczema
- ◻ Hair Loss
- ◻ Psoriasis
- ◻ Rashes

Eyes/Ears/Nose/Throat
- ◻ Glaucoma
- ◻ Blurry Vision
- ◻ Dizziness
- ◻ Hearing Loss
- ◻ Ringing in Ears
- ◻ Loss of Smell
- ◻ Frequent Nosebleeds
- ◻ Difficulty Swallowing

MEN'S HEALTH HISTORY

Have you had any prostate problems? Yes__ No__

Testoterone tested/using supplements?_____

Hair Loss/Thinning? Yes__ No__

WOMEN'S HEALTH HISTORY

Total number of pregnancies: _____ Number of births: _____ Date of last menstrual period?_____

Painful menstruation? Yes__ No__ Irregular cycle? Yes__ No__ Do you take birth control pills? Yes__ No__

Breast problems? Yes__ No__ Menopause: Yes__ No__

Doctor's Notes:

SURGERIES AND ACCIDENTS

Surgery/Hospitalization _____ Date _____ Reason/Diagnosis _____

_____ _____ _____

Accidents/Injuries ___ Fractured/Broken bone ___ Injured in an accident ___ Been knocked unconscious ___ Had a sprain/strain

_____

GENERAL HISTORY

How would you rate your diet? Good___ Fair___ Poor___

Water: Approx. how many ounces per day?_____

Exercise: Yes__ No__ Activity_____

Stretch: Yes__ No__ How often_____

Sleep: Side___ Back___ Elevated___ Stomach___ Chair___ CPAP___

Stress Level: 1___ 2___ 3___ 4___ 5___ 6___ 7___ 8___ 9___ 10___

Hobbies/ Sports: _____

_____

Work: Full Time___ Part Time___ School___ Retired___ Disability___ Other_____

Postion_____ Description_____

Medications (Please include both prescriptions and over-the-counter medications)

_____

_____

_____

Vitamins/Supplements

_____

_____

SOCIAL HISTORY

Do you drink alcohol on a regular basis? Yes__ No__ Servings per day_____

Do you smoke or use tobacco products/vape/marijuana? Yes__ No__ How much?_____

Have you smoked in the past? Yes__ No__ When did you quit?_____

Do you consume caffeine daily? Yes__ No__ How much? _____

FAMILY HISTORY

Relationship	Age (if living)	Medical Conditions
Mother	_____	_____
Father	_____	_____

Patient or Authorized Person Signature _____

Date _____