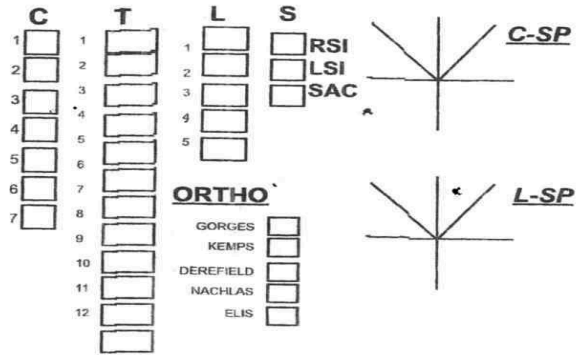
Codes:



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FULL NAME:	DATE:
DATE OF BIRTH :	
___MALE _____ FEMALE	MARITAL STATUS SINGLE MARRIED OTHER
MAILING ADDRESS:	
PHYSICAL ADDRESS:	
PHONE NUMBER	
EMERGENCY CONTACT/SPOUSE INFO:	PHONE#
EMAIL ADDRESS:	

☐ PLEASE PROVIDE A COPY OF YOUR ID

PLACE OF EMPLOYMENT:	
PHONE NUMBER:	
OCCUPATION:	
WHO IS RESPONSIBLE FOR VISIT BILLS?:	SELF____ PERSONAL INJURY CASE____.
IF PERSONAL INJURY CASE: WORKPLACE ____ or	AUTO INJURY___.
WORKMANS COMP OR ATTORNEY INFO:	
PRIMARY CARE PHYSICIAN:	PHONE #

HIPAA PRIVACY PRACTICES

I acknowledge that I have received and/or have been given the opportunity to review Doc Brown Chiropractic & Wellness's Notice of HIPAA Privacy Practices for protected health information.

PATIENT SIGNATURE:	DATE:
CONSENT TO TREAT MINOR	
PARENT/GUARDIAN SIGNATURE:	DATE:

PATIENT HISTORY

HAVE YOU BEEN SEEN BY A CHIROPRACTOR BEFORE?

YES NO

CHIROPRACTIC HISTORY :

- ☐ NECK PAIN
- ☐ STIFF NECK
- ☐ COLD HANDS
- ☐ COLD FEET
- ☐ SLEEP PROBLEMS
- ☐ NUMBNESS IN FEET
- ☐ NUMBNESS IN HANDS
- ☐ BACK PAIN
- ☐ ARTHRITIS
- ☐ TENSION
- ☐ MUSCLE SPASMS
- ☐ DIZZINESS
- ☐ FAINTING
- ☐ JOINT PAIN /SWELLING
- ☐ WEAKNESS IN ARMS OR LEGS
- ☐ SHOULDER PAIN
- ☐ ARM PAIN
- ☐ LEG PAIN
- ☐ HIP PAIN
- ☐ LOSS OF BALANCE
- ☐ Headaches (Frequency) _____ .

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MEDICAL HISTORY	Are you under the care of a Physician?	YES or NO
Are you Pregnant?	YES or NO	How many weeks/months are you?
Have you ever been hospitalized or had major surgery?	YES or NO	details:
Have you ever had serious head, neck or back surgery?	YES or NO	details:
Do you have any allergies?	YES or NO	
Are you taking any Medications?	YES or NO	

MEDICAL CONDITIONS:	PLEASE MARK ALL THAT APPLY	OTHER:
☐ AIDS/HIV	☐ BLOOD DISORDER	☐ G.I. ISSUES
☐ DEPRESSION	☐ EMPHYSEMA	☐ HERNIA
☐ GOUT	☐ HEART DISEASE	☐ LIVER DISEASE
☐ HERPES	☐ HIGH BLOOD PRESSURE	☐ PARKINSONS
☐ MISCARRIAGE	☐ M.S	☐ STROKE
☐ PACEMAKER	☐ PROSTATE	☐ CHRONIC FATIGUE
☐ FIBROMYALGIA	☐ BRONCHITIS	☐ GLAUCOMA
☐ ASTHMA	☐ HEPATITIS	☐ HERNIATED DISC
☐ DIABETES	☐ KIDNEY DISEASE	☐ MIGRAINE
☐ HEART ATTACK	☐ OSTEOPOROSIS	☐ POLIO
☐ HIGH CHOLESTEROL	☐ SEIZURES	☐ THYROID PROBLEMS
☐ MONO	☐ CANCER	☐ PNEUMONIA

SOCIAL HISTORY PLEASE MARK **N**ever **O**ccasionally **R**egularly	**FAMILY HISTORY** PLEASE MARK **P**ARENT **S**IBLING **G**RANDPARENT
CAFFEINE USE Amount . ALCOHOL USE Amount . EXERCISE . NICOTINE USE . WEAR SEAT BELT .	CANCER . DIABETES . HEAT DISEASE . HIGH BLOOD PRESSURE . STROKE . THYROID . OTHER:

SYMPTOMS MAP **PLEASE MARK USING THE LETTERS TO INDICATE YOUR DISCOMFORT**

N- Numbness

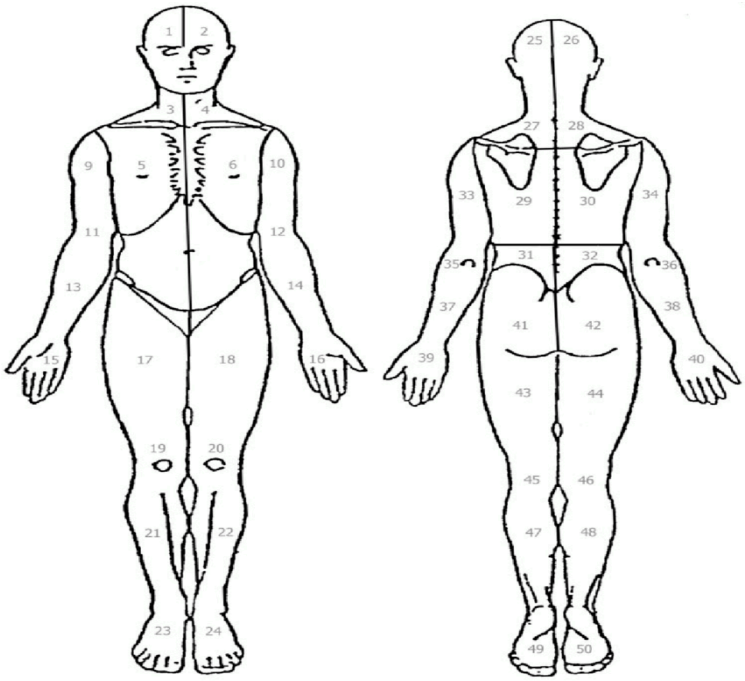
B- Burning

S- Stabbing

T-Tingling

A-Ache

X- Pain



Describe your Symptoms:_____.

When/How did they begin?:_____.

PAIN LAST 24 HOURS	**PAIN IN THE LAST WEEK**
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Please mark your answer with 0-100%

How often do you experience your pain/ discomfort?_____.

How much does your symptoms interfere with your daily activities?_____.

Please circle the answer that best fits.

How would you describe the state of your symptoms over time? **Better, Slightly Better, Unchanged, Much Worse**	How would you describe your general state of health right now? **Excellent, Very Good, Good, Fair, Poor**

PATIENT CONSENT FOR TREATMENT

Doc Brown Chiropractic & Wellness
CHIROPRACTIC CONSENT TO TREAT

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, whom i am legally responsible) by the Doctor of Chiropractic indicated above and/other licensed doctors or chiropractic support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the Doctor of Chiropractic named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not. I have had an opportunity to discuss with the Doctor of Chiropractic named above and/or with other office or clinic personnel the nature and purpose of Chiropractic adjustments and procedures . I understand that results are not guaranteed and there is no promise of cure. I further understand and i am informed that, as in the practice of medicine in the practice of chiropractic there are some risks to treatment , including but not limited to, fractures, disc injuries, stroke, dislocations, and sprains I do not expect the Doctor to be able to anticipate and explain all risks and complications, and i wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time,based upon the facts then known, is in my best interest. I further understand that there are treatment options available for my condition other than Chiropractic procedures. These treatment options include but are not limited to, self administered over the counter analgesics and rest , medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; Physical therapy; steroid injection; bracing' and surgery. I understand and have been informed that I have the right to a second opinion and to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Initial_____.

PATIENT ACKNOWLEDGMENT AND RECEIPT OF NOTICE OF PRIVACY PRACTICES PURSUANT TO *HIPAA* AND CONSENT FOR USE OF HEALTH INFORMATION.

The undersigned does hereby acknowledge that he/she has received /reviewed a copy of this office's notice of Privacy practices pursuant to *HIPAA* and has been advised that a full copy of this *HIPAA* compliance manual is available upon request. The undersigned do hereby consent to the use of his or her health information in a manner consistent with the notice of privacy practices pursuant to *HIPAA*, the *HIPAA* compliance manual, State Law, and Federal Law.

Initial_____.

I understand and agree that the health insurance policies are an arrangement between insurance carriers and myself. Furthermore I understand that Dr. Stanley Brown will prepare any necessary reports and forms to assist *me* in making collections from my insurance company. I authorize payments from Attorney's/insurance company settlements or benefits to be paid directly to Dr. Stanley Brown, DC. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payers to secure payment. However, I clearly understand that if I suspend or terminate my care and treatment,any fees for professional services rendered will be immediately due and payable.

PATIENTS PRINTED NAME:_____.

PATIENTS SIGNATURE:_____DATE_____.

.

NAME OF MINOR PATIENT:_____DATE_____.

SIGNATURE OF PARENT/GUARDIAN AUTHORIZING CARE:

_____.