

CONFIDENTIAL PATIENT HISTORY/INFORMATION:

Patient name _____ SSN or ID# _____ Birth date _____

Age _____ Are you covered by Medicare or Medicaid? YES / NO. If YES, we will need a copy of your Health ID Card for our file.

Address _____ (Apt#) _____ City/State/Zip _____

Home phone: _____ Work: _____, ext. _____ Cell: _____

May we contact you, or leave message, at the numbers listed above? YES / NO ? If NO, contact/message phone _____

E-mail address _____ (office hours, information & online scheduling at www.watsonchiropractic.com)

Occupation/ Job Title _____ Employer name _____

Employer address _____

Marital status, Married/ Single/ Divorced/ Widowed (circle one).

Emergency Contacts:

Spouse/Guardian name _____ phone _____

Name of relative/friend not living with you _____ phone _____

Major Complaint(s) _____

Onset date of current complaint(s) _____ Is your condition accident related? YES / NO (circle one)

Is condition due to injury or sickness from being at your place of WORK? or while on the JOB? AUTO? OTHER? (circle one, if applicable)

List activities that aggravate your condition: _____

Is condition progressively getting worse? YES / NO. Is condition interfering with Work? _____ Sleep? _____ Daily routine? _____

Other? _____ (mark all that apply, and include description if you mark "Other").

Have you missed days from work due to this complaint? YES / NO

Have you seen any other doctors for this complaint? YES/ NO. If yes, name of doctor, when? _____

Do you have a family physician? YES / NO. If yes, name of doctor, city? _____

Date of last physical exam _____ . If female, are you pregnant? YES / NO

How much water do you drink per day? NONE / 1-8oz / 8-16oz / 16-24oz / 24-32oz / 32-40oz / 40-48oz / 48-56oz / 56-64oz / + 64oz

Do you take vitamins or minerals? YES / NO. If yes, write name(s) _____

Do you use Alcohol _____ Caffeine _____ Tobacco _____? (mark all that apply)

Drugs? (Include prescription and non prescription drugs, such as birth control, aspirin, heart medicine, laxatives, cold tablets, etc...)

TYPE	PURPOSE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List all surgeries and dates: _____

List major falls, accidents, injuries, and date(s): _____

Have you ever fractured a bone? YES / NO. If yes, list bone/bones, and date(s): _____

Do you have, or have you had, a serious illness? YES / NO. If yes, name of illness(es): _____

List any complications of your own birth (ie, forceps, cesarean, breech, birth injury/fracture): _____

List any known injuries during your growth and development (ie, fall down stairs, fall out of bed, fall off bike, hit by car, hit head, dog bite): _____

Have you ever been diagnosed with the following conditions? Please mark "Y" for YES and leave blank for NO.

Stroke____ Cancer____ Tuberculosis____ Polio____ Pleurisy____ Enlarged thyroid____ High blood pressure____
Low blood pressure____ Diabetes____ HIV virus/Aids____ Carpal tunnel syndrome____ Alcoholism____ Concussion____

If you are suffering from any of the following, please mark with: **O=Occasionally, F= Frequently, C=Constantly, Blank=Never**

____ Headaches	____ Hand pain	____ Bronchitis	____ Sciatica	<u>Female</u>
____ Dizziness	____ Finger pain	____ Asthma	____ Leg pain	____ Irregular menstrual cycle
____ Ringing in ears	____ Finger cramping	____ Rib pain	____ Knee pain	____ Hot flashes
____ Ear infections	____ Numbness in arms/hands/fingers	____ Shingles	____ Foot pain	____ Excess menstruation
____ Jaw pain	____ Tingling in arms/hands/fingers	____ Abdominal pain	____ Toe pain	____ Endometriosis
____ Congestion	____ Mid back pain	____ Ulcers	____ Numbness in legs/feet/toes	____ Severe cramps
____ Allergies	____ Mid back stiffness	____ Difficulty breathing	____ Tingling in legs feet toes	
____ Neck pain	____ Burning along spine	____ Colon problem	____ Ache in legs	
____ Neck stiffness	____ Indigestion/heartburn	____ Low back pain		
____ Shoulder pain		____ Low back stiffness		
____ Elbow pain		____ Hip pain		

Additional comments: _____

Watson Chiropractic, P.C. may, from time to time, contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. Watson Chiropractic, P.C. may call you by telephone or notify you by e-mail as an appointment reminder or regarding missed appointments, or leave a message with your voice mail, or answering machine, or with the individual answering the phone. Watson Chiropractic, P.C. may also send letters, cards, or information pertinent to your condition, new research, or treatment options to the address you provided for that purpose. Your information on this form or in your file will be kept confidential in our office(s). We may disclose your health information to family, friend, or other person, but only if you agree we may do so. In the event of death or emergency circumstances we may disclose health information using our professional judgement disclosing only information that is directly relative to person's involvement. We may disclose your health records when required to do so by law. Your health records will not be released to other providers (doctors) or attorneys without your signed authorization. At any time, you may request we send correspondence to a confidential location by filling out a Confidential Communication Request form. You also have the right to limit or restrict disclosure of your records. You may request to append, inspect and/or copy your medical records for up to 7 years following date service rendered. Watson Chiropractic may charge a fee for administrative costs related to copying and mailing your records.

I understand payment is due at time of service unless insurance payment arrangements are made with this office. I understand I am financially responsible for 100% of charges. I understand if I do not pay, in full at time services rendered, I will not receive a discount of 20% on those services (this 20% discount does not apply to any supplement or supply charges). I understand I am responsible for all collection costs and attorney fees related to any unpaid balance. I understand my health information on this form and documented in my file may be shared with my insurance company or other payors. I authorize the release of any medical or other information necessary to process any claims submitted to my insurance company or other payors. I request payment of government or medical benefits to either myself or to Gonzzo Watson, D.C. dba Watson Chiropractic, P.C. for any bills/claims for services rendered to me. I hereby give my permission to the doctor to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and treatment of my condition. I permit a copy of this authorization to be used in place of the original.

I received the Notice of Privacy Practices, and had an opportunity to review it.

I have read, understand, and agree to the previous statement(s).

Patient /Parent/Guradian signature _____ Today's Date _____