# INTRODUCTION PATIENT CASE HISTORY

**Today's Date: _____**

## PATIENT INFORMATION

**Name:** (Last, First MI)_____ **Preferred Name**: _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Home:** _____ **Mobile:** _____ **Mobile Carrier:** _____ **Work:** _____

**Email:** _____ **Gender:** M / F **Marital Status:** Married / Other / Single

**Social Security #**:_____ **Date of Birth:** _____

**Student Status:** Full Student / Part Student / Non-Student ☐ **Employed** **Employer:** _____

***Referred By:** _____

**Ethnicity**: Hispanic or Latino / Other **Preferred Language:** _____

**Race:** Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White

**Smoking Status**: Every Day / Some Days / Former / Never

## EMERGENCY CONTACT INFORMATION

**Full Name:** _____ **Primary Care Physician:** _____

**Home:** _____ **Mobile:** _____ **Doctor's Phone:** _____

**Relationship**: Child / Parent / Spouse / Other: _____

## FINANCIAL INFORMATION

☐ Insurance ☐ Worker's Comp ☐ Self-Pay (Cash) ☐ Personal Injury/Auto ☐ Other (please explain):_____

**PRIMARY INSURANCE**

**Name:** _____

**Relation to Insured:** Self / Spouse / Parent / Child / Other

*Other than Self:*
**Insured's Name**: _____ **Gender:** M / F

**Address**: _____

**City:** _____ **State:** _____ **Zip:** _____

**Phone:** _____ **Date of Birth:** _____

**SECONDARY INSURANCE**

**Name:** _____

**Relation to Insured:** Self / Spouse / Parent / Child / Other

*Other than Self:*
**Insured's Name**: _____ **Gender:** M / F

**Address**: _____

**City:** _____ **State:** _____ **Zip:** _____

**Phone:** _____ **Date of Birth:** _____

**Who is responsible for payment?** Self / Other - *(Relationship)* _____

*Other than Self:*
**Full Name**: _____ **Phone:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

***It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged***

**Patient No:** _____

# Consents

**Consent to Bill/Collect Insurance:** I consent, if I am using a third party for payment of my services (health insurance, auto accident insurance, worker's compensation insurance, Parent/Guardian, etc), to allow Thrive Chiropractic Group to submit all necessary information needed to receive payment for the services I received to these third parties. I further consent to accept assignment of payments from my insurance company to be paid directly to the clinic or doctor.

| _____ | _____ | _____ |
|---|---|---|
| Patient/Guardian Name | Patient/Guardian Signature | Date |

**Consent to Examination and Treatment:** I give the doctors and staff of Thrive Chiropractic Group permission to perform all examinations, x-rays, and treatment deemed necessary by the doctor. I understand that some of these procedures may be performed by either the staff or the doctor.

| _____ | _____ | _____ |
|---|---|---|
| Patient/Guardian Name | Patient/Guardian Signature | Date |

**Consent to Retrieve Medical Records:** I give the doctors and staff of Thrive Chiropractic Group permission to obtain any and all medical records from other providers, offices or hospitals which may assist with my care.

| _____ | _____ | _____ |
|---|---|---|
| Patient/Guardian Name | Patient/Guardian Signature | Date |

**HIPPA:** A copy of the full Health Information Privacy Policy for our clinic can be requested at our front desk. In brief, it states that we will not give any information about you except as consented to above. The only people we give information to is parents/guardians if you are a minor or whomever is responsible for your bill (i.e. insurance company, third party, or attorney if you have one).

| _____ | _____ | _____ |
|---|---|---|
| Patient/Guardian Name | Patient/Guardian Signature | Date |

**Clinical Summary Report (CCR):** I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Thrive Chiropractic Group to save these electronically for me and not print them out after each visit. I understand that, upon written request, these reports are available to be printed or emailed to me for review.

| _____ | _____ | _____ |
|---|---|---|
| Patient/Guardian Name | Patient/Guardian Signature | Date |

**Pregnancy Waiver (Women Only):** By my signature below, I am stating that to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this time.

| _____ | _____ | _____ |
|---|---|---|
| Patient/Guardian Name | Patient/Guardian Signature | Date |

# PEDIATRIC QUESTIONNAIRE

**Name:** (Last, First MI)_____ **Today's Date:** _____

## PEDIATRIC REVIEW OF SYSTEMS

**Pediatric:**

- ☐ ADHD
- ☐ Allergies/Asthma
- ☐ Autism
- ☐ Back/Neck Pain
- ☐ Bed Wetting
- ☐ Behavioral issues
- ☐ Chronic Earaches
- ☐ Colic
- ☐ Constipation
- ☐ Growing Pains
- ☐ Nightmares
- ☐ Reflux
- ☐ *None in this Category*

**Childhood Diseases:**

- ☐ Chicken Pox: Age ____
- ☐ Measles: Age ____
- ☐ Meningitis: Age ____
- ☐ Mumps: Age ____
- ☐ Rubella: Age ____
- ☐ Tuberculosis: Age ____
- ☐ Whooping Cough: Age ____
- ☐ Other:_____ Age ____
- ☐ *None in this Category*

**Has your child been vaccinated?**

☐ **No** ☐ **Yes**

*(Any Adverse Reactions? – Describe:)*_____

_____

## INFANTS AND NEWBORNS

**Prenatal History:**

**Location of Birth:** ☐ Home ☐ Birthing Center ☐ Hospital

**Birth Weight:** _____ **Birth Length:** _____ **Full Term?** ☐ **No** ☐ **Yes** *(Describe)*_____

**Complications during pregnancy?** ☐ **No** ☐ **Yes** *(Describe)* _____

**Medications during pregnancy or delivery?** ☐ **No** ☐ **Yes** *(List)* _____

**Cigarette / Alcohol / Drugs during pregnancy?** ☐ **No** ☐ **Yes** *(List)* _____

**Birth Interventions?** ☐ **No** ☐ **Yes** ☐ Forceps ☐ Vacuum ☐ Caesarian ☐ Other: _____

**Complications during delivery?** ☐ **No** ☐ **Yes** *(Describe)* _____

**Feeding History:**

**Breast fed?** ☐ **No** ☐ **Yes** *(How Long?)* _____ **Formula fed?** ☐ **No** ☐ **Yes** *(How Long?)* _____ *(Type?)* _____

**Introduced to cereal at ____ months old.** **Solids at____ months old.** **Cow's milk at____ months old.**

**Food / Juice allergies or intolerances?** ☐ **No** ☐ **Yes** *(Describe)* _____

**Developmental History:**

**Sleep** *(Hours per Night?)* _____ **Problems Sleeping?** *(Describe)* _____ _____

## CONSENT FOR TREATMENT OF A MINOR

I hereby authorize: _____ *(Doctor's Name)* and whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary to: _____ *(Minor Patient's Name)*

_____
Printed Name of Parent or Guardian

_____ _____
Signature of Parent or Guardian Date

_____ _____
Witness Date

**Patient No:** _____