For office use only:

Patient File No._____

Clayton Chiropractic
201 East Main St. Clayton, NC 27520
Health History Form

PATIENT DATA

Today's Date_____ **How did you hear about us**?_____ **Age**:_____

First Name: _____ **Last Name**_____**Birth Date**_____ **SSN** _____

Address_____**City**_____**State**_____**Zip**_____

Telephone (Cell)_____**(Home)**_____**Email***_____

* Your email will NOT be shared with any 3rd parties, and may be used for occasional office announcements and promotions.

Occupation_____**Employer**_____**Marital Status**_____

Spouse's Name_____**Spouse's Birth Date**_____**No. of Children** _____

In case of an emergency, please notify_____**Relationship**_____**Phone**_____

Preferred Contact number for Billing and Questions:_____

**Please note these questions are being asked in compliance with CMS meaningful use:*

Race: ⧫White ⧫Black or African American ⧫ Asian ⧫ Hispanic ⧫ American Indian ⧫ Chinese ⧫ Filipino ⧫ Native Hawaiian or other Pacific Island ⧫ Japanese ⧫ Decline to Provide ⧫ Other:_____
Multi-Racial: ⧫ Yes ⧫ No ⧫Unknown **Preferred Language**: ⧫ English ⧫ Spanish ⧫ Other:_____
Ethnicity: ⧫ Hispanic or Latino ⧫ Not Hispanic or Latino ⧫ Decline to Provide

Verification Question: (Choose only one question by circling the question, then give the answer to that question)
⧫ What's the name of your favorite pet? ⧫ In what city where you born? ⧫ What high school did you attend? ⧫ On what street did you grow up? ⧫ What was the make of your first car?

Verification Answer: _____

INSURANCE INFORMATION

Name of Party Responsible for Payment:_____Phone_____
Do you have Health Insurance? ⧫ Yes ⧫ No Name of Company:_____
If an auto accident, please provide:
Insurance Company Name:_____ Contact Person: _____

SIGNATURES

I understand and agree that health/accident insurance policies are an agreement between an insurance carrier and me. I understand and agree that all services rendered to me and charged are my responsibility and that payment is required for all services at the time they are rendered. Applicable co-payments and deductibles will be collected. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable. I understand that any balance that is not paid in full within 90 days will be subject to an additional 30% collection fee. I agree in order for you to service my account or to collect any amounts I may owe, you may contact me by telephone at any telephone number associated with my account. This includes wireless telephone numbers, which could result in charges to me. I/We have read this disclosure and agree that Clayton Chiropractic may contact me/us as described above.

Patient's signature _____ Spouse/Guardian's signature _____ Date _____

Current Complaints

Nature of Injury: ○Automobile ○ Work ○ Other

Please describe Injury:

Date of Injury:_____ Date symptoms appeared:_____ Have you ever had same condition? When? _____

List of other practitioners seen for this injury/condition: _____

Have you ever been under chiropractic care? ○ No ○ Yes If yes, when & please describe:

Have you had X-rays taken?○ No ○ Yes If yes, when & where? _____

Do you experience pain every day?	○ No	○ Yes
Do your symptoms interfere with daily life?	○ No	○ Yes
Does pain wake you up at night?	○ No	○ Yes
Are your symptoms worse during certain times of the day?	○ No	○ Yes
Do changes in weather affect your symptoms?	○ No	○ Yes
Do you wear orthotics?	○ No	○ Yes

What activities aggravate your symptoms?

Medical History

Primary Care Provider:_____ Telephone Number:_____

Have you been treated for any condition in the last year? ○ No ○ Yes If yes, please describe_____

Date of last physical exam _____Is there a chance that you are pregnant? ○ No ○ Yes

List any medication/supplements you are currently taking. Include dosage and amounts, etc.

List any known allergies you have to any medications.

Have you ever:		**Briefly Explain**
Broken bones?	○ No ○ Yes	
Been hospitalized?	○ No ○ Yes	
Been in an auto accident?	○ No ○ Yes	
Had sprains/strains?	○ No ○ Yes	
Been struck unconscious?	○ No ○ Yes	
Had surgery?	○ No ○ Yes	

Habits:	**None**	**Light**	**Moderate**	**Heavy**
Alcohol	○	○	○	○
Coffee	○	○	○	○
Soft Drinks	○	○	○	○
Water	○	○	○	○
Appetite	○	○	○	○
Salty Foods	○	○	○	○
Sugary Foods	○	○	○	○
Artificial Sweeteners	○	○	○	○
Tobacco	○	○	○	○
Drugs	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○

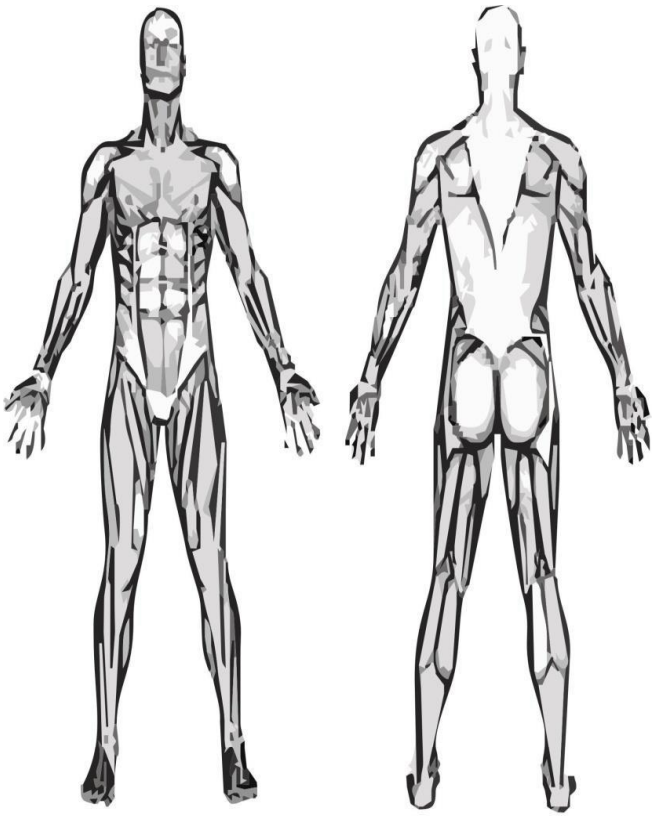
Family History (present & past health conditions):

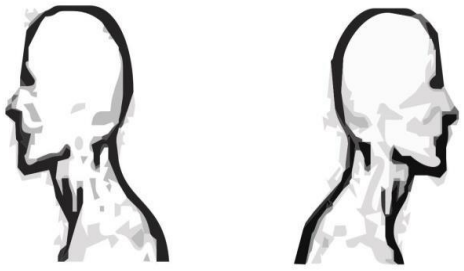
Have you ever suffered from:

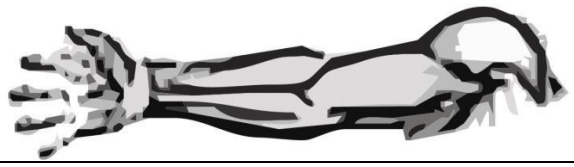
- ○ Alcoholism
- ○ Allergies
- ○ Anemia
- ○ Arteriosclerosis
- ○ Arthritis
- ○ Asthma
- ○ Back Pain
- ○ Bronchitis
- ○ Bruise Easily
- ○ Cancer
- ○ Chest Pains
- ○ Cold Extremity
- ○ Constipation
- ○ Cramps
- ○ Depression
- ○ Diabetes
- ○ Digestion Problems
- ○ Dizziness
- ○ Ears Ringing
- ○ Excessive Menstruation
- ○ Eye Pain or Difficulties
- ○ Fatigue
- ○ Frequent Urination
- ○ Headache
- ○ Hemorrhoids
- ○ High Blood Pressure
- ○ Hot Flashes
- ○ Irregular Heart Beat
- ○ Irregular Menstrual Cycle
- ○ Kidney Infection
- ○ Kidney Stones
- ○ Loss of memory
- ○ Loss of balance
- ○ Loss of smell
- ○ Loss of taste
- ○ Lumps In Breast
- ○ Neck Pain or Stiffness
- ○ Nervousness
- ○ Nosebleeds
- ○ Pacemaker
- ○ Polio
- ○ Poor Posture
- ○ Prostate Trouble
- ○ Sciatica
- ○ Shortness of breath
- ○ Sinus Infection
- ○ Sleep problems
- ○ Insomnia
- ○ Spinal Curvatures
- ○ Stroke
- ○ Swelling of ankles
- ○ Swollen Joints
- ○ Thyroid Condition
- ○ Tuberculosis
- ○ Ulcers
- ○ Varicose Veins
- ○ Venereal Disease
- ○ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing







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