

Skin: I DENY having any of the symptoms or problems listed below.

- changes in nail texture hair loss itching skin lesions / ulcers
- changes in skin color hives paresthesias varicosities
- hair growth history of skin disorders rash

Nervous System: I DENY having any of the symptoms or problems listed below.

- dizziness limb weakness numbness slurred speech tremor
- facial weakness loss of consciousness seizures stress unsteadiness of gait/loss of balance
- headache loss of memory sleep disturbance strokes

Psychologic: I DENY having any of the symptoms or problems listed below.

- anhedonia behavioral change convulsions memory loss
- anxiety bi-polar disorder depression mood change
- loss or change in appetite confusion insomnia

Allergy: I DENY having any of the symptoms or problems listed below.

- anaphalaxis itching chronic nasal congestion sneezing
- food intolerance acute nasal congestion rash

Hematologic: I DENY having any of the symptoms or problems listed below.

- anemia blood clotting bruising easily lymph node swelling
- bleeding blood transfusion fatigue

PAST HEALTH HISTORY– Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition: I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? Yes No. If yes, Who? (Name) _____

Type of Treatment: _____ Was the treatment beneficial in resolving condition? Yes No

Explain: _____

Previous Chiropractic Care: I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

Childhood Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

- ADD chicken pox headaches scoliosis
- atopic dermatitis (eczema) crohn's/colitis hepatitis seizure disorder
- allergies/hayfever depression HIV sickle cell anemia
- anemia diabetes measles spina bifida
- asthma ear infections mumps other:
- bedwetting fetal drug exposure psoriasis
- cerebral palsy food allergies (list below) rash

Adult Illness(es): LIST all health conditions. CIRCLE all CURRENT conditions.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> cystic kidney disease | <input type="checkbox"/> hypertension | <input type="checkbox"/> psychiatric problems |
| <input type="checkbox"/> alzheimers | <input type="checkbox"/> depression | <input type="checkbox"/> influenzal pneumonia | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease | <input type="checkbox"/> seizures |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lung disease | <input type="checkbox"/> shingles |
| <input type="checkbox"/> asthma | <input type="checkbox"/> eczema | <input type="checkbox"/> lupus erythema (discoïd) | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> cancer | <input type="checkbox"/> emphysema | <input type="checkbox"/> lupus erythema (systemic) | <input type="checkbox"/> STD's (unspecified) |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> eye problems | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> suicide attempt(s) |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> parkinson's disease | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> heart disease | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> CRPS (RSD) | <input type="checkbox"/> hepatitis | <input type="checkbox"/> pneumonia | <input type="checkbox"/> other: |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> HIV | <input type="checkbox"/> psoriasis | |

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> angioplasty | <input type="checkbox"/> cosmetic | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy | <input type="checkbox"/> D & C | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff |
| <input type="checkbox"/> caesarian section | <input type="checkbox"/> dental surgery | <input type="checkbox"/> joint replacement | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder | <input type="checkbox"/> knee repair | <input type="checkbox"/> tonsilectomy |
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy | <input type="checkbox"/> other: |
| <input type="checkbox"/> coronary artery bypass | <input type="checkbox"/> hernia repair | <input type="checkbox"/> mastectomy | |

Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- | | | |
|---|---|--|
| <input type="checkbox"/> back injury | <input type="checkbox"/> head injury (loss of consciousness) | <input type="checkbox"/> motor vehicle accident |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild) |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe) | <input type="checkbox"/> joint injury | <input type="checkbox"/> soft tissue injury (severe) |
| <input type="checkbox"/> fracture | <input type="checkbox"/> laceration (severe) | <input type="checkbox"/> other: |

Insurance Information:

Who Is Responsible For Your Bill? **YOU** and... (mark appropriate box(es)) Myself **ONLY**

Spouse Worker's Comp Auto Insurance Medicare Medicaid Other (be specific): _____

Personal Health Insurance Carrier: _____ Health ID Card #: _____

Policy Holder's Name: _____ Group #: _____

Policy Holder's Date of Birth: ____ - ____ - ____ Primary Care Physician: _____

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date: ____/____/____ Time: ____ am/pm

Carrier: _____ Policy # _____

Carriers Phone #: (____) _____ - _____ Adjuster: _____

Claim #: _____

Office Agreement

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand Alta View Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Alta View Chiropractic will be credited to my account upon receipt. **HOWEVER, I CLEARLY UNDERSTAND THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.**

I understand that I am responsible for any co-payments, deductibles or co-insurance at the time of service.

A monthly Late Fee charge of 5% of \$5.00, the greater of the two, will be charged to all accounts after 60 days.

I also understand that if I suspend or terminate my care, and/or treatment, any fees or professional services rendered me will immediately be due and payable. I agree that I will be personally responsible for all collection fees (up to 50% of the account balance) if my account is turned over for collection, as well as any attorney fees and litigation costs if legal action becomes necessary to collect this amount.

We understand that from time to time appointments may need to be changed, however, any appointment not cancelled with at least 24 hours notice will be charged a non-cancellation fee of \$35.00

Release of information : The Facility is required by law to make and keep records of the Patient's medical treatment. The Facility safeguards those records and it uses and discloses such records and the information they contain only in accordance with the State and Federal privacy laws. Such uses and disclosures are described in detail in the Facility's Notice of Privacy Practices, which may be amended from time to time. I understand that either the Patient or I may ask to see a copy of the current notice at any time.

I acknowledge that the Clinic's Notice of Privacy Practices for protected health information was made available to me.

Patient Print Name: _____

Patient's Signature: _____ Date: _____

DO NOT WRITE BELOW THIS : FOR OFFICE USE ONLY

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? yes or no.

Family History: Mark all that apply below. List any specific conditions past or present after has/had:

general family	<input type="checkbox"/> alive	<input type="checkbox"/> deceased	<input type="checkbox"/> normally developed	<input type="checkbox"/> no significant disease	<input type="checkbox"/> has/had: _____
father	<input type="checkbox"/> alive	<input type="checkbox"/> deceased	<input type="checkbox"/> normally developed	<input type="checkbox"/> no significant disease	<input type="checkbox"/> has/had: _____
mother	<input type="checkbox"/> alive	<input type="checkbox"/> deceased	<input type="checkbox"/> normally developed	<input type="checkbox"/> no significant disease	<input type="checkbox"/> has/had: _____
paternal grandfather	<input type="checkbox"/> alive	<input type="checkbox"/> deceased	<input type="checkbox"/> normally developed	<input type="checkbox"/> no significant disease	<input type="checkbox"/> has/had: _____
paternal grandmother	<input type="checkbox"/> alive	<input type="checkbox"/> deceased	<input type="checkbox"/> normally developed	<input type="checkbox"/> no significant disease	<input type="checkbox"/> has/had: _____
maternal grandfather	<input type="checkbox"/> alive	<input type="checkbox"/> deceased	<input type="checkbox"/> normally developed	<input type="checkbox"/> no significant disease	<input type="checkbox"/> has/had: _____
maternal grandmother	<input type="checkbox"/> alive	<input type="checkbox"/> deceased	<input type="checkbox"/> normally developed	<input type="checkbox"/> no significant disease	<input type="checkbox"/> has/had: _____
son (s)	<input type="checkbox"/> alive	<input type="checkbox"/> deceased	<input type="checkbox"/> normally developed	<input type="checkbox"/> no significant disease	<input type="checkbox"/> has/had: _____
daughter(s)	<input type="checkbox"/> alive	<input type="checkbox"/> deceased	<input type="checkbox"/> normally developed	<input type="checkbox"/> no significant disease	<input type="checkbox"/> has/had: _____
brother(s)	<input type="checkbox"/> alive	<input type="checkbox"/> deceased	<input type="checkbox"/> normally developed	<input type="checkbox"/> no significant disease	<input type="checkbox"/> has/had: _____
sister(s)	<input type="checkbox"/> alive	<input type="checkbox"/> deceased	<input type="checkbox"/> normally developed	<input type="checkbox"/> no significant disease	<input type="checkbox"/> has/had: _____

Patient Accepted : Yes No Referred to _____

Doctor's Signature



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