WELCOME TO BRINK CHIROPRACTIC CLINIC

Patient Name:_________________________________ Birth Date: __________________

Mailing Address: ______________________________ Sex: M F

City ____________________ State _____ Zip________ SSN: _____-____-________

Preferred Phone #: _____________________________ Marital Status M S W D

Alternate Phone # ______________________________ Spouse Name: _____________________

Email: ____

Employer _____________________________________ Occupation_______________________

Would you like to receive appointment reminders? **YES NO** if YES **TEXT or EMAIL**

If there is someone that you would like to authorize to access your records, appointment information (PHI) and information about the balance on your account (FINANCIAL) enter their information below:

Name ___________________________ DOB___________ PHI ☐ FINANCIAL☐ .

Emergency Contact: __________________________ Phone #: (_____)____________

Do you have an advanced care plan or a surrogate decision maker ? **YES NO**

Who may we thank for referring you to this office: ____________________________________

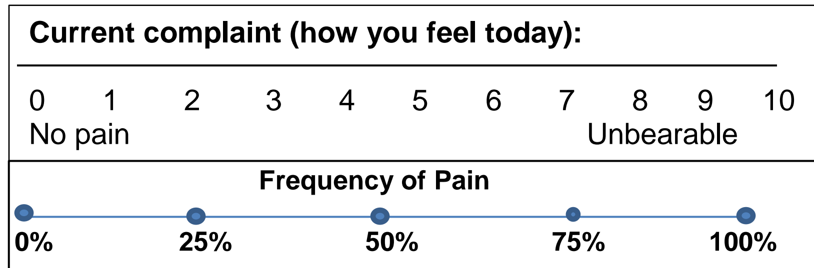
Primary Care Physician: ______________________ Length of time in their care: ____________

Is your current condition the result of an accident? **NO YES** if yes circle one (**HOME WORK AUTO**)

If it was a work accident, Did you file a report with your employer? **YES NO**

Have you had similar injuries before, if so when? ___________________

Have you lost time from work: **YES NO** Dates: ________________



Date problem began ____________________

How problem began _____________________

____

____

OTHERS SEEN FOR THIS CONDITION

Physician: ____________________________ Length of time treated: _________________

Treatment Provided: ____

Results:__________________________ Diagnosis: ______________________________

Have you had any X-RAYS, MRI's or CT scans? YES NO When? ______ At what Facility:_____ ___

Patient or Guardian Signature ____________________________________ **Date** ________________

Pt Name _______________

Account # ______________

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN

What type of exercise do you perform on a daily basis? None ___ Light ___ Moderate ___ Heavy ___

What do your daily work habits include? (Ex. Sitting, standing, light labor, computer work) ________________

____

FAMILY HISTORY: please indicate family member ie: mother (**M**), father (**F**), sibling(**S**):

__________Cancer: Type _____________ _________ Diabetes _________ High Blood Pressure

__________ Heart Problems _____________Stroke ______________Rheumatoid Arthritis

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PATIENT HISTORY

Abnormal Weight ___Gain ___Loss		Falls within the past 12 months	**YES NO**	Pain at Night	**YES NO**
Taking Birth Control Pills	**YES NO**	High Blood Pressure	**YES NO**	Pain Unrelieved by Position or Rest	**YES NO**
Taking Blood Thinners	**YES NO**	Marked Morning Pain/Stiffness	**YES NO**	Prostate Problems (Male only)	**YES NO**
Taking Corticosteroids	**YES NO**	Menstrual Problems (Female only)	**YES NO**	Recent Fever or Chills	**YES NO**
Currently Pregnant # weeks ______		Numbness in Groin/Buttocks	**YES NO**	Stroke (Date)_________	**YES NO**
Diabetes	**YES NO**	Osteoarthritis	**YES NO**	Urinary Problems	**YES NO**
Dizziness/Fainting	**YES NO**	Osteoporosis	**YES NO**	Visual Disturbances	**YES NO**
Epilepsy/Seizures	**YES NO**	Pacemaker	**YES NO**		

MEDICATION: DOSE: FREQUENCY: ROUTE:

____
____
____
____

SURGERIES, CANCERS, OR OTHER HEALTH CONCERNS:

____
____
____
____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, ____, have received (or been offered and declined) a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to; Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment. Obtain payment from third-party payers. Conduct normal health care operations such as quality assessments and accreditation.

____
Patient Name (printed)

____
Signature **Relationship to patient** **Date**

I certify to the best of my knowledge, the provided information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive health care benefits through this provider, I understand that I am liable for all the charges for services rendered and I agree to notify this office immediately whenever I have changes in my health condition or health plan coverage in the future. **I understand that I am liable for charges incurred in this office**. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed; therefore, I give authorization to my chiropractor to contact my physician and share information if necessary.

Patient Signature____ **Date:** _________________

I give either William G Brink DC and/or Daniel A Brink DC permission to evaluate and treat my son/daughter/dependent

_____________________, of whom I am their parent or legal guardian. I accept responsibility for payment of charges.

Guardian Signature ____ **Date:** _______________

The following questions are for statistical purposes only and would never be used to discriminate against you. You may opt to not answer if you wish.

Do you currently smoke? YES NO Packs per day? ____ Have you smoked in the past? YES NO How long ago? ______

Preferred Language:
____ English
____ Other _________________

Ethnicity:
____ Hispanic or Latino
____ Not Hispanic or Latino

Race:
_____ American Indian or Alaskan Native
_____ Asian
_____ Black or African American
_____ Native Hawaiian or Other Pacific Islander
_____ White