Welcome to Brink Chiropractic Clinic

Patient Name:		**Birth Date:**	
Mailing Address:		**Sex:**	Male Female
City:		**Marital Status:**	M S D W
State and Zip Code:		**Spouse Name:**	
Cell Phone:		**Referred by:**	
Alternate Phone:		**Alt Phone Type:**	Home Work Other:
Email:		**Employer:**	
Reminder Format:	Text Email None	**Occupation:**	

Emergency Contact Information			
Name:		**Phone:**	
Do you have an advanced care plan or a surrogate decision maker?			
If there is someone that you would like to authorize to access your records, enter their information below and indicate which type of information you would like to give them access to:			
Name:		**Birth Date:**	
☐ **PHI - Records and appointment information**		☐ **FINANCIAL – Information about your balance**	

Medical Information			
Primary Care Doctor:		**Length of time in their care:**	
X-rays, MRI's or CT Scans?	Yes No When:	**At What Facility?**	
Your Current Condition			
How problem began:		**Date problem began:**	
Current Pain Level:	**0 1 2 3 4 5 6 7 8 9 10** No Pain Unbearable Pain		
Frequency of Pain:	**0% 20% 40% 60% 80% 100%**		
Similar injuries before?	Yes No When?		
Lost time from work?	Yes No	**If so, what dates?**	
Others seen for this condition:		**Length of time treated:**	
Treatment provided:		**Results/Diagnosis:**	
Is this a result of an accident?	**Yes No When:**	**Type of Accident:**	**Home Work Auto**

The above information is true and correct to the best of my knowledge. If any of the above information changes, I will inform the office immediately.	
Patient Signature (or Guardian if under 18):	**Date:**

Patient History

For Office Use Only	PT Name _____ Account # _____

What type of exercise do you perform daily?	None	Light	Moderate	Heavy
What do your daily work habits include?	Sitting	Standing	Light Labor	Computer Work

Check any of the following that apply to you:

☐ Abnormal Weight Gain	☐ Epilepsy/Seizures	☐ Pacemaker
☐ Abnormal Weight Loss	☐ Falls Within Last 12 Months	☐ Pain at Night
☐ Taking Birth Control Pills	☐ High Blood Pressure	☐ Pain Unrelieved by Position or Rest
☐ Taking Blood Thinners	☐ Marked Morning Pain/Stiffness	☐ Prostate Problems (Male only)
☐ Taking Corticosteroids	☐ Menstrual Problems (Female Only)	☐ Recent Fever or Chills
☐ Currently Pregnant ___weeks	☐ Numbness in Groin/Buttocks	☐ Stroke – Date:
☐ Diabetes	☐ Osteoarthritis	☐ Urinary Problems
☐ Dizziness/Fainting	☐ Osteoporosis	☐ Visual Disturbances

Medications, Including Dose, Frequency, Route:	Surgeries, Cancers, or Other Health Concerns:

Family History – Please indicate which family member: M (Mother), F (Father), S (Sibling) for each item checked

☐ Cancer – Type:	☐ Diabetes	☐ High Blood Pressure
☐ Heart Problems	☐ Stroke	☐ Rheumatoid Arthritis

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?	No Yes ____# Packs per Day	**Race:**	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
Smoked in the Past?	No Yes - How long ago?		
Ethnicity	☐ Hispanic or Latino ☐ Not Hispanic or Latino		

Acknowledgement of Receipt of HIPAA Privacy Notice

I, (print name)_____, 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, and Conduct normal health care operations such as quality assessments and accreditation.

_____ _____ _____

Signature **Relationship to Patient** **Date**

I certify to the best of my knowledge that 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 permission for _____ , of whom I am the parent/legal guardian, to be evaluated and treated at Brink Chiropractic Clinic. **I accept responsibility for payment of charges.**

Guardian Signature: _____ **Date:** _____