Office Use:
Acct # : _____
Last Adj: _____

Patient Health History Information

ROCK SOLID CHIROPRACTIC

☐ ***Marion: 308 5th Ave, Marion, ND 58466***

Date: _____

First Name: _____ Last Name: _____ (Nickname Preferred)**:**_____

Cell # (___) _____—_____ Home # (___) _____—_____ Work # (___) _____—_____ ext. _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Age: _____ Birth Date: _____

Appointment Reminder Preference: ☐ Text Reminders: (___) _____—_____ ☐ Phone Call: (___) _____—_____

Emergency Contact (*Name*): _____ *(Relation)* _____ Phone # (___) _____—_____

Occupation: _____ Employer: _____

Marital Status: M S W D Name of Spouse: _____

Names/Ages Children: _____

How were you ***referred*** to our office? _____

Family Medical Doctor:_____ ☐ Currently without a regular medical doctor
Address: _____
Phone: _____

When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐ Yes ☐ No

***Please check all insurance/coverage options that may be applicable to your case*:** ☐ *Major Medical* ☐ *Medicare* ☐ *Auto Accident* ☐ *Worker's Compensation* ☐ *Medical Savings Account & Flex Plans* ☐ *CareCredit* ☐ *No Coverage* ☐ *VA*

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company *(if applicable)*: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Rock Solid Chiropractic, PLLC. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the ***HIPAA NOTICE*** *that is available to you at the front desk before signing this consent.*

Initial applicable boxes indicating your preference(s) to receive messages regarding personal information:

☐ Cell ☐ Home ☐ Work ☐ Email ☐ No messages may be left regarding personal information.

The following person(s) have my permission to receive my personal health information:

_____

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Updated: 9/24/2019 @ 5:17pm

ROCK SOLID CHIROPRACTIC

Patient Name_____ **Date**_____

HISTORY OF PRESENT ILLNESS

Chief Complaint(s) *or* *Purpose* of this appointment: _____

Date symptoms appeared or accident occurred: _____

Have you ever had the same or a similar condition(s)? ☐ No ☐ Yes

Describe conditions, if applicable:_____

How did it *originally* occur? _____

Has it become worse recently? ☐ Yes ☐ No ☐ Same ☐ Better ☐ Gradually Worse

If *yes*, when and how? _____

How frequent is the condition? ☐ Constant ☐ Daily ☐ Intermittent ☐ Night Only ☐ Morning_____

How long does it last? ☐ All Day ☐ ____ Hours / ____ Minutes

Describe the pain: ☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing

☐ Other _____

What relieves the problem? _____

What aggravates the problem? _____

What activities are on hold due to pain? _____

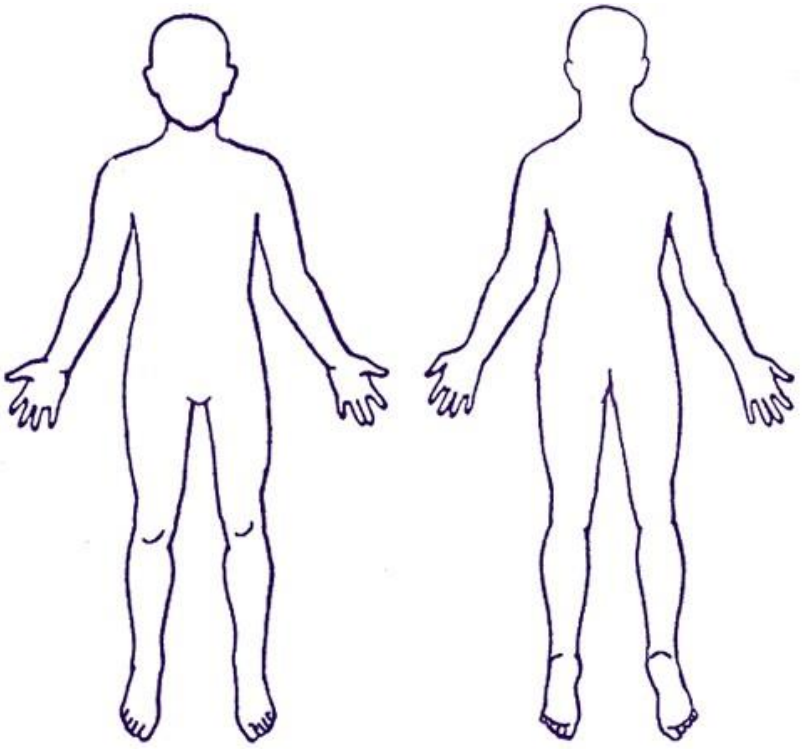
Days lost from work: _____ Work Duties: _____

Are there any other conditions or symptoms that may be related to your major symptom? ☐ Yes ☐ No ☐ Unsure

If *yes*, describe: _____

NO SYMPTOMS — **EXTREME SYMPTOMS**

Please place an "X" on the line above to indicate level of problem.



Front Back

SUBJECTIVE PAIN ASSESSMENT

Indicate *the location of your symptoms on the drawing using the following description:*

A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

⟵ =Shooting or traveling

Example: ST placed between the shoulder blades indicated stabbing pain in that location.

ROCK SOLID CHIROPRACTIC

Patient Name_____ **Date**_____

HEALTH HISTORY

List ***ALL*** **injuries, falls, auto-accidents, major illnesses or surgeries over lifetime. *Doctors determine relevance*:**

_____

_____

_____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No
If yes, describe: _____

What medications, drugs, or supplements are you taking? For medications, list what it is being used to treat, and how long you have been taking it. _____

_____

Do you have any allergies of any kind? ☐ Yes ☐ No If ***yes***, describe:_____

Do you have any Congenital Condition? ☐ Yes ☐ No If ***yes***, describe:_____

For Women: Are you pregnant? _____ *If **yes**, when is your due date?* _____

Previous births vaginal or cesarean (include complications, if any) _____

Please indicate if you are or have experienced the conditions listed below as follows: ***"N"= NOW*** *or* ***"P"= PAST***

Headaches_____
Frequency_____
Location_____
Neck Pain or Stiffness_____
Back Pain or Stiffness_____
Numbness/Tingling_____
Location_____
Loss of Strength_____
Location_____
Arthritis_____
Location_____
Type_____
Bones/Fractures_____
Location_____
Joint Pain/Swelling_____
Location_____
Muscle Spasms_____
Location_____

Heart Disease_____
High Blood Pressure_____
Low Blood Pressure_____
Chest Pain/ Tightness_____
Shoulder/Arm/Neck pain _____
Circulation Problems_____
Hands/Feet Cold_____
Excessive Bleeding_____
Stroke_____
Pacemaker_____

Frequent Colds_____
Type_____
Fever_____
Fatigue_____
Reason_____
Weight Loss or Gain (circle)
Amount_____
Timeframe_____
Diabetes_____
Osteopenia or Osteoporosis (circle)
Cancer_____
Type_____
Treatment_____
HIV Positive_____

Indigestion_____
Ruptures_____
Location_____
Gall Bladder Problems_____
Ulcers_____
Unusual Bowel Patterns_____
Frequency_____
Consistency_____

Sleeping Problems_____
Due to: pain or busy mind (circle)
Nervousness_____
Cause_____
Tension_____
Cause_____
Irritability_____
Cause_____
Depression_____
Cause_____
Loss of Memory_____
Loss of Balance_____
Dizziness_____
Fainting_____
Seizures_____
Ears Ring or Buzz_____
Loss of Taste_____
Loss of Smell_____
Trouble with Eyes_____
Describe_____
Eating Disorder_____
Type_____
Drug Addiction_____
Alcoholism_____

Doctor's Notes:

ROCK SOLID CHIROPRACTIC

Patient Name_____ **Date**_____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:

OFTEN= "O" SOMETIMES= "S" NEVER= "N"

Vigorous Exercise_____	High Stress Activity_____
Moderate Exercise_____	Family Pressures_____
Type_____	Financial Pressures_____
Alcohol Use: _____	Other Mental Stress_____
Drug Use: _____	Other (specify) _____
Tobacco Use: _____	
Caffeine Use: _____	

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						
Age/cause of death:						

I certify the information provided is accurate to the best of my knowledge:

Signature of Patient/Legal Guardian _____ Date _____