ROCK SOLID CHIROPRACTIC

Office Use:
Acct # : _____
Last Adj: _____

Patient Health History Update Form

Falcon: 11605 Meridian Market View #142, Falcon, CO 80831

(719) 799-6565

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: (___) _____—_____

Occupation: _____ Employer: _____

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

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:_____

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? _____

If you did not have pain, what activities would you be enjoying? _____

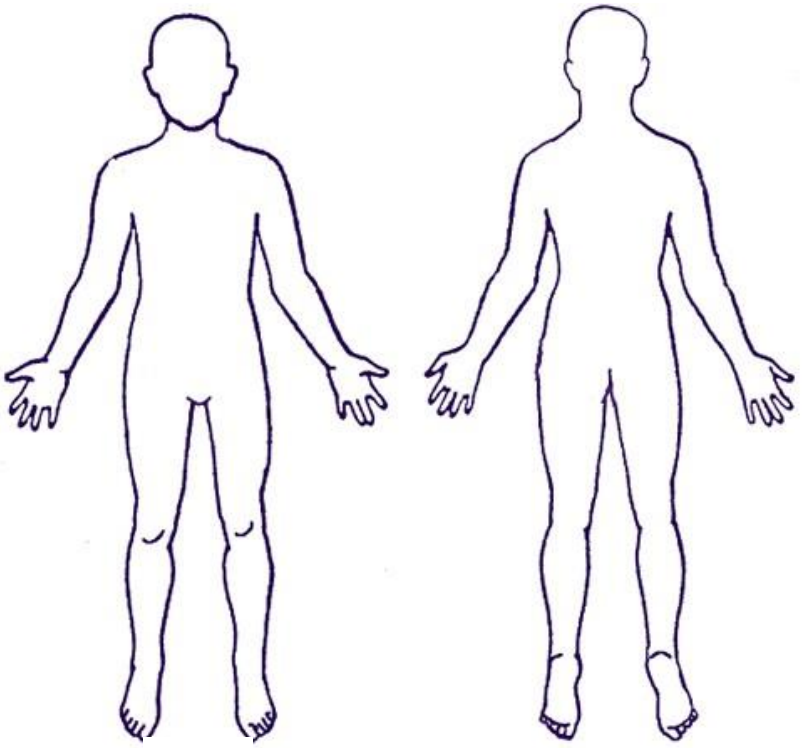
Days lost from work: _____ Work Duties: _____

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.