



CONFIDENTIAL PATIENT INFORMATION

Full Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: _____ SSN: _____

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

Mobile Phone: _____

Work Phone: _____

Home Phone: _____

Email Address: _____

Occupation: _____ Employer: _____

Employer Address: _____

Spouse's Employer: _____

Do you have Medicare coverage? Yes ☐ No ☐

Primary Insurance (Member ID/Group#): _____

Secondary Insurance (Member ID/Group#): _____

Spouse's Name: _____ Spouse Date of Birth: _____

Number of Children? _____ Women: Are you pregnant? Yes ☐ No ☐ If so, how many weeks? _____

Due Date? _____

Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐

In Case of Emergency Contact: _____ Phone: _____

Do you wish to authorize any person to request or discuss your protected health information with us? Yes ☐ No ☐

Name of authorized person and relationship to you: _____

Who may we thank for referring you to us?

If you were not referred to us, how did you choose our office?

Please describe the problem(s) that brought you to our office for care: ("1"=Minimal, "10"=Excruciating/Severe)

1. _____ Please circle your level of pain **right now**. 1 2 3 4 5 6 7 8 9 10
Please circle your pain **most of the time**. 1 2 3 4 5 6 7 8 9 10
Please circle your pain **at its best**. 1 2 3 4 5 6 7 8 9 10
Please circle your pain **at its worst**. 1 2 3 4 5 6 7 8 9 10
2. _____ Please circle your level of pain **right now**. 1 2 3 4 5 6 7 8 9 10
Please circle your pain **most of the time**. 1 2 3 4 5 6 7 8 9 10
Please circle your pain **at its best**. 1 2 3 4 5 6 7 8 9 10
Please circle your pain **at its worst**. 1 2 3 4 5 6 7 8 9 10

How long have you been experiencing these problems? _____

Getting Better ☐ Getting Worse ☐ Not Changing ☐

What other health care providers have you consulted for help? (Check all that apply)

Medical Doctor ☐ Specialist MD (Orthopedist, Neurologist, Surgeon, etc.) ☐ Doctor of Chiropractic ☐

Physical Therapist ☐ Massage Therapist ☐ Acupuncturist ☐ Other ☐: _____

Are you taking pain medications, anti-inflammatory medication, or muscle relaxants for this condition? Yes ☐ No ☐

Which type, how much, and how often? _____

This problem is affecting my: Work ☐ Relationships ☐ Sleep ☐ Daily Routines ☐ Exercise ☐ Recreation ☐

Do you currently use tobacco of any kind? Yes ☐ Former Smoker ☐ Never a Smoker ☐

Are you taking any other medications at this time? Please list them:

Stress can have a profound effect on your health and well-being. Please rate your present level of stress on a scale of 1-10, "1" being very little/no stress and "10" being very intense/debilitating stress:

Stress at home: _____ Stress at work: _____ Stress "in general": _____

Please mark the following conditions you may have had or have now (- have had + have now):

- | | | | | | |
|--|---|---|---|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergy | <input type="checkbox"/> Anemia | <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> COVID-19 | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestion Issues | <input type="checkbox"/> Eczema | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Gout | <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Hormone Issues | <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Migraines | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> M.S. | <input type="checkbox"/> Mumps | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Spine Fracture | <input type="checkbox"/> Stroke | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Whooping Cough | | | |

Other conditions not named above: _____

I hereby authorize Powers Chiropractic, PC to release any information necessary to process insurance claims. I assign all benefits payable directly to Cory G. Powers, D.C. Health insurance may not pay for services considered maintenance, supportive, or deemed "not medically necessary" even though you may want the care, need the care to prevent worsening of your condition, have symptoms that respond to chiropractic care, or have a certain number of "visits" in your policy. I agree that I am financially responsible for all non-covered services.

X _____
Patient or Parent/Legal Guardian Signature *Date*

I hereby authorize Cory G. Powers, D.C. to treat my condition as he deems appropriate through the use of chiropractic adjustments and any other treatment modalities within the scope of his license. I understand and accept any risks associated with this type of treatment. I understand that Dr. Powers is not responsible for treatment of previously diagnosed medical conditions that are outside his scope of practice or for treatment for conditions that I have not disclosed.

X _____
Patient or Parent/Legal Guardian Signature *Date*

I acknowledge that the Privacy Notice (HIPAA) has been made available to me.

X _____
Patient or Parent/Legal Guardian Signature *Date*