JASKOWIAK CHIROPRACTIC
JOURNEY TOWARDS A MENDED LIFE

Patient Demographic Information

Full Name:_____

Address:_____

City:_____ State:_____ Zip:_____

E-mail:_____ Preferred Phone:_____

Birth Date:_____ Race:_____ Sex: _____

Height: _____ ft _____ in Weight: _____ lbs

Marital Status: Married Single Divorced Widowed

Spouse Name: _____

Occupation:_____ Full/Part Time:_____

Employer: _____ Employer's Address:_____

Office Phone:_____

How many children? _____ Names and Ages of Children:_____

_____

Emergency Contact: _____

Relation:_____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. 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. The following person(s) have my permission to receive my personal health information:

_____

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Medical History

Date of last physical examination: _____ Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

_____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe:_____

What medications or drugs are you taking? If you do not take any medications, leave chart blank

Nerve Pills	
Painkillers (including aspirin)	
Muscle relaxers	
Blood pressure medicine	
Insulin	
Stimulants	
Blood thinners	
Tranquilizers	
Over-the-counter	
Nutritional supplements	
Additional medications	

Do you have any allergies to any medications? Yes No If yes, describe:_____

_____

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

_____

Do you have any Congenital Condition(s)? Yes No If yes, describe:_____

_____

Smoker: Yes No Former | Alcohol consumption: Daily 4x-5x/wk 2x-3x/wk 0x-1x/wk

Caffeine consumption: Always Often Sometimes Never | Exercise routine: Daily 4x-5x/wk 2x-3x/wk 0x-1x/wk

Exercise type: Vigorous (cardio/heavy weight lifting) Moderate (light weight lifting/jogging) Mild (walking/yoga)

Do you wear: Heel lifts Sole lifts Inner soles Arch supports None

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Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**. (N = Now P = Previously)

Headaches/Migraines		Loss of taste		Joint pain/swelling	
Neck pain		Unusual bowel patterns		Menstrual difficulties	
Loss of balance		Cold feet		Chest pains/tightness	
Fainting		Cold hands		Dizziness	
Stiff neck		Arthritis		Shoulder/neck/arm pain	
Sleeping problems		Muscle spasms		Numbness in fingers	
Back pain		Frequent colds		Numbness in toes	
Nervousness		Fever/Rheumatic fever		High/low blood pressure	
Tension		Sinus problems		Difficulty urinating	
Irritability		Diabetes		Weakness in extremities	
Loss of smell		Indigestion problems		Breathing problems	
Fatigue		Lights bother eyes		Ears ring	
Excessive bleeding		Rheumatoid arthritis		Broken bones/fractures	
Osteoarthritis		Heart surgery/pacemaker		Stroke	
Ruptures		Eating disorder		Drug addiction	
Gallbladder problems		Ulcers/Colitis		Sudden weight loss/gain	
Depression		Loss of memory		Buzzing in ears	
Circulation problems		Seizures/Epilepsy		Low blood pressure	
Osteoporosis		Heart troubles/disease		Cancer	
Coughing blood		Alcoholism		HIV Positive	
Hepatitis		Pain between shoulders		Kidney problems	
Congenital heart defect		Asthma		Venereal disease	
Tuberculosis		Shingles		Chemotherapy	
Anemia		High cholesterol		Thyroid Problems	

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SOCIAL HISTORY

Please indicate beside each activity whether you engage in it: OFTEN= "O" SOMETIMES= "S" NEVER= "N"

Family Pressures		Work Pressures	
Financial Pressures		Mental Stresses	
High Stress Activities		Other_____	
Other_____		Other_____	

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 [ ]	BROTHER(S) Age [ ] Age [ ]	SISTER(S) Age [ ] Age [ ]	CHILD(REN) 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					

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CONDITION	FATHER Age [ ]	MOTHER Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTER(S) Age [ ] Age [ ]	CHILD(REN) Age [ ] Age [ ]
Nervousness					
Neuritis					
Neuralgia					
Pinched Nerve					
Scoliosis					
Sinus Trouble					
Stomach Trouble					
Other:					

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

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____