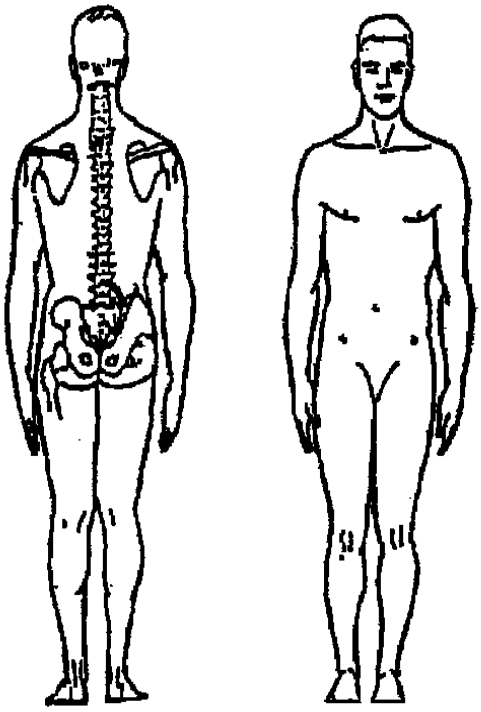
N8 HEALTH CENTERS

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT.

Today's Date _____
Name _____ Home Phone _____ Work Phone _____
Cell Phone _____ E-Mail Address _____
Address _____ City _____ State _____ Zip _____
Age _____ Birth Date _____ Marital Status: S☐M☐W☐D☐Number of Children _____
Driver's License # _____ Name of Spouse or Parent _____

Your Employer _____ Occupation _____ Years On Job ____
Office Phone # _____ # of Hours/ Week You are Currently Working _____
Insurance Company _____ Your Social Security # _____
Do you have Medicare? Yes ☐ No ☐ Do you have Medicaid? Yes ☐ No ☐



COMPLETE THESE DIAGRAMS

If you are experiencing pain, please mark the exact location on the diagram.

MAJOR COMPLAINTS

Please list any condition you are being treated for or are experiencing.

_____
_____
_____
_____
_____
_____

Is your condition due to an accident? Yes ☐ No ☐
Date of accident? _____
Type of accident? Auto _____ Work/On Job _____ At Home _____

Describe:_____

Who do we need to thank for sending you to our office?: _____

CONTACT IN CASE OF EMERGENCY:

NAME _____RELATIONSHIP:_____PHONE: _____

Financial Policy

N8 Health Centers are Private Pay facilities and does not participate with any insurance carriers. All fees for services are paid by the patient. If you have any insurance or third party coverage, N8 Health Centers will provide you with a superbill for reimbursement from your company according to your contract.

Traditional Medicare
As a curtesy, N8 Health Centers submits claim forms directly to Medicare. Medicare will reimburse patients according to its guidelines for covered services. N8 Health Centers makes no guarantees as to reimbursement.

I (we) agree to pay for services rendered. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all collection cost, attorney, and legal fees if legal action becomes necessary to collect this amount. I hereby authorize the doctor to treat my condition as he/she deems appropriate through the use of Chiropractic Adjustments and Therapies. I hereby acknowledge that I have been informed that if x-rays are necessary, that there will be a fee charged for those x-rays. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

How payment will be made: ☐ Cash ☐ Check ☐ Credit Card

Patient's Signature _____ Date _____
Or Guardian Signature _____ Date _____

Insurance
As a curtesy, N8 Health Centers will contact your Health Insurance Carrier to get an estimate on your contract's reimbursement of covered services. If you are interested, please **provide your insurance card** or fill out the following information:

Insurance Company _____ Insured's Name _____
Insured's Date of Birth_____ Relationship to Insured _____
Policy Number_____ Group Number _____ Claim Number_____
Phone Number _____ Website
_____

HIPPA Form
Medical Information Release of Information- I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to my spouse, child(ren), and or physician at request. This Release of Information will remain in effect until terminated by me in writing. Messages: Please call my work, home or cell phone. If unable to reach me, please leave a detailed message. I fully understand the above information and accept the policies of this office. N8 Health Centers reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy.

☐ I Consent ☐ I Do Not Consent
Signature:_____

Name _____ Date _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

O – OCCASIONAL
F – FREQUENT
C – CONSTANT

O F C

GENERAL

- ☐ ☐ ☐ Allergy
- ☐ ☐ ☐ Chills
- ☐ ☐ ☐ Convulsions
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Loss of sleep
- ☐ ☐ ☐ Loss of weight
- ☐ ☐ ☐ Gaining weight
- ☐ ☐ ☐ Nervousness/depression
- ☐ ☐ ☐ Neuralgia
- ☐ ☐ ☐ Numbness
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Tremors

MUSCLE & JOINT

- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Fibromyalgia
- ☐ ☐ ☐ Foot trouble
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Low back pain
- ☐ ☐ ☐ Lumbago
- ☐ ☐ ☐ Neck pain or stiffness
- ☐ ☐ ☐ Pain between shoulders

Pain or numbness in:

- ☐ ☐ ☐ Shoulders
- ☐ ☐ ☐ Arms
- ☐ ☐ ☐ Elbows
- ☐ ☐ ☐ Hands
- ☐ ☐ ☐ Hips
- ☐ ☐ ☐ Legs
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ Feet

- ☐ ☐ ☐ Painful tail bone
- ☐ ☐ ☐ Poor posture
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Spinal Curvature
- ☐ ☐ ☐ Swollen joints

O F C

GASTRO-INTESTINAL

- ☐ ☐ ☐ Belching or gas
- ☐ ☐ ☐ Colitis
- ☐ ☐ ☐ Colon trouble
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult digestion
- ☐ ☐ ☐ Distension of abdomen
- ☐ ☐ ☐ Excessive hunger
- ☐ ☐ ☐ Gall bladder trouble
- ☐ ☐ ☐ Hemorrhoids
- ☐ ☐ ☐ Intestinal worms
- ☐ ☐ ☐ Jaundice
- ☐ ☐ ☐ Liver trouble
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Pain over stomach
- ☐ ☐ ☐ Poor appetite
- ☐ ☐ ☐ Vomiting
- ☐ ☐ ☐ Vomiting of blood

EYES, EARS, NOSE &THROAT

- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Colds
- ☐ ☐ ☐ Crossed eyes
- ☐ ☐ ☐ Deafness
- ☐ ☐ ☐ Dental Decay
- ☐ ☐ ☐ Earache
- ☐ ☐ ☐ Ear discharge
- ☐ ☐ ☐ Ear noises
- ☐ ☐ ☐ Enlarged glands
- ☐ ☐ ☐ Enlarged thyroid
- ☐ ☐ ☐ Eye pain
- ☐ ☐ ☐ Failing vision
- ☐ ☐ ☐ Far sightedness
- ☐ ☐ ☐ Gum trouble
- ☐ ☐ ☐ Hay fever
- ☐ ☐ ☐ Hoarseness
- ☐ ☐ ☐ Nasal obstruction
- ☐ ☐ ☐ Near sightedness
- ☐ ☐ ☐ Nosebleeds
- ☐ ☐ ☐ Sinus infection
- ☐ ☐ ☐ Sore throat
- ☐ ☐ ☐ Tonsillitis

O F C

CARDIO-VASCULAR

- ☐ ☐ ☐ Hardening of arteries
- ☐ ☐ ☐ High blood pressure
- ☐ ☐ ☐ Low blood pressure
- ☐ ☐ ☐ Pain over heart
- ☐ ☐ ☐ Poor circulation
- ☐ ☐ ☐ Rapid heart beat
- ☐ ☐ ☐ Slow heart beat
- ☐ ☐ ☐ Swelling of ankles

RESPIRATORY

- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ Difficult breathing
- ☐ ☐ ☐ Spitting up blood
- ☐ ☐ ☐ Spitting up phlegm
- ☐ ☐ ☐ Wheezing

SKIN

- ☐ ☐ ☐ Boils
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Dryness
- ☐ ☐ ☐ Hives or allergy
- ☐ ☐ ☐ Itching
- ☐ ☐ ☐ Skin eruptions (rash)
- ☐ ☐ ☐ Varicose veins

GENITO-URINARY

- ☐ ☐ ☐ Bed-wetting
- ☐ ☐ ☐ Blood in urine
- ☐ ☐ ☐ Frequent urination
- ☐ ☐ ☐ Inability to control kidneys
- ☐ ☐ ☐ Kidney infection or stones
- ☐ ☐ ☐ Painful urination
- ☐ ☐ ☐ Prostate trouble
- ☐ ☐ ☐ Pus in urine

FOR WOMEN ONLY

- ☐ ☐ ☐ Congested breasts
- ☐ ☐ ☐ Cramps or backache
- ☐ ☐ ☐ Excessive menstrual flow
- ☐ ☐ ☐ Hot flashes
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Menopausal symptoms
- ☐ ☐ ☐ Painful menstruation
- ☐ ☐ ☐ Vaginal discharge

☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Chorea
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

List surgical operation and years: _____
_____

Prescription medications: Dosage: Reason for taking:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

**If taking more than five medications, please continue list on the back of this form*

Over the counter medications: Frequency: Reason for taking:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports
Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never
Describe: _____
Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? _____

HAVE YOU EVER:	Yes	No	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	_____
Used a cane, crutch, or other support?	☐	☐	_____
Been treated for a spine or nerve disorder?	☐	☐	_____
Had a fractured bone?	☐	☐	_____
Been hospitalized for anything other than surgery?	☐	☐	_____

DO YOU:			
Now take vitamins or minerals?	☐	☐	_____
Have any allergies?	☐	☐	_____

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X- ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐

Health Goals

*Please check **<u>all</u>** that apply:*

Restore Function ☐

Reverse Disease ☐

Increase Function ☐

More Energy ☐

Improve Mood/Mental Outlook ☐

Sleep Better ☐

Improve Quality of Life ☐

Relieve Pain ☐

Lose Weight ☐

Reduce Healthcare Costs ☐

Improve Athletic Performance ☐

Get Back to Hobbies or Other Activities ☐

Increase Flexibility ☐

Eliminate Medications ☐

Prevent Disease ☐

Maintain Independence ☐

Overall Health and Vitality ☐

I want to be able to _____

Other: _____