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 PATIENT INFO Today's Date _____

Name _____ Age _____ Birth Date _____

Your Social Security # _____

Home Phone _____Cell Phone _____

E-Mail Address _____

Address _____ City _____ State _____ Zip _____

Marital Status: S M W D Number of Children _____Name of Spouse_____

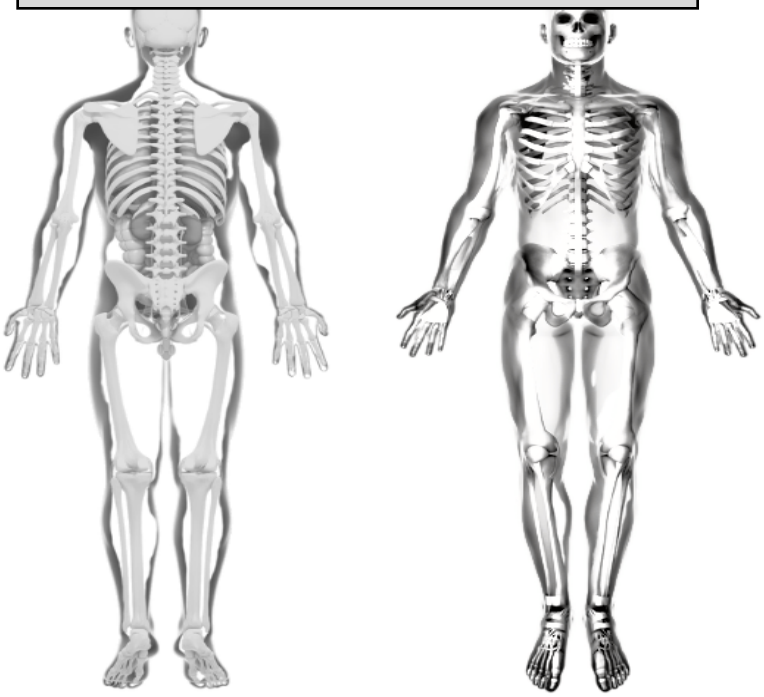
Emergency Contact:_____ Phone:_____

Your Employer _____ Occupation _____ Years On Job ____

Phone # _____ # of Hours/ Week You are Currently Work_____

Do you have insurance? Y N If Yes, complete info on insurance page.
Major Medical▢ Medicare▢ Medicaid▢

Use the diagram below to mark any areas of concern.
N-Numbness, P-Pain, T-tingling, R-Radiating



List any issues you are currently experiencing

_____
_____
_____
_____

Is your condition due to an accident? Yes _____ No _____
Date of accident? _____
Type of accident? Auto _____ Work _____ Other _____

Rate your pain over the last week:
Minimum Maximum
1 2 3 4 5 6 7 8 9 10

Acceptable level of pain after completion of treatment:
Minimum Maximum
1 2 3 4 5 6 7 8 9 10

Who do we need to thank for referring you to our office?

_____

Financial Policy

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 to me will be immediately due and payable. I agree that I will be responsible for all collection costs, 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 all treatments available. 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.

Insurance
As a courtesy, N8 Health Centers will contact your Health Insurance Carrier to get an estimate on your contract's reimbursement of covered services.

Traditional Medicare
As a courtesy, N8 Health Centers submits claim forms directly to Medicare. Medicare will reimburse our clinics according to its guidelines for covered services. N8 Health Centers make no guarantees as to reimbursement and a patient could be responsible for any non-covered Medicare service(s).

Insurance Info:
Insurance Company _____ Insured's Name _____

Insured's DOB_____ Relationship to Insured _____

Insured's Phone Number _____

Policy Number_____ Group Number _____

Do you have secondary insurance? Y N
If Yes, please complete:
Insurance Company _____ Insured's Name _____

Insured's DOB_____ Relationship to Insured _____

Insured's Phone Number _____

Policy Number_____ Group Number _____

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

Patient's Signature _____ Date _____

Guardian Signature _____ Date _____

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 you are 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 list any individuals/entities that you give permission to release information to:

_____

_____

_____

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 b/t shoulders

Pain or numbness in:

□ □ □ Shoulders
□ □ □ Arms
□ □ □ Elbows
□ □ □ Hands
□ □ □ Hips
□ □ □ Legs
□ □ □ Knees
□ □ □ Feet
□ □ □ Tailbone
□ □ □ Poor posture
□ □ □ Sciatic
□ □ □ Spinal Curvature

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 sighted
□ □ □ Gum trouble
□ □ □ Hay fever
□ □ □ Hoarseness
□ □ □ Nasal obstruction
□ □ □ Near sighted
□ □ □ 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 heartbeat
□ □ □ 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
□ □ □ Unable to control kidneys
□ □ □ Kidney infection
□ □ □ Kidney 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	□ Cold sores	□ Goiter	□ Miscarriage	□ Scarlet fever
□ Anemia	□ Diabetes	□ Gout	□ Multiple sclerosis □	□ Stroke
□ Appendicitis	□ Diphtheria	□ Heart disease	Mumps	□ Tuberculosis
□ Arteriosclerosis	□ Eczema	□ Influenza	□ Pleurisy	□ Typhoid fever
□ Arthritis	□ Emphysema	□ Lumbago	□ Pneumonia	□ Ulcers
□ Cancer	□ Epilepsy	□ Malaria	□ Polio	□ Venereal disease
□ Chorea	□ Fever blisters	□ Measles	□ Rheumatic fever	□ Whooping cough

List surgical operation and years:

_____

_____

_____

_____

Prescription medications: Dosage: Reason for taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

**If taking more than five medications, please continue the 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? _____

	Y	**N**
HAVE YOU EVER:	□	□
Been knocked unconscious?	□	□
Used a cane, crutch, or other support?	□	□
Been treated for a spine or nerve disorder?	□	□
Had a fractured bone?	□	□

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	□	□	□	□

Health Goals

*Please circle **all** 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: _____

X-Ray Consent Form

Name:_____

Date:_____ Time:_____ a.m. p.m.

I authorize N8 Health Centers to perform such radiographic examinations necessary to diagnose and to administer whatever treatment is deemed necessary to treat my present condition or illness.

Print Name:_____

Signature:_____

Witness:_____

For Women Only:

Pregnancy Release

This is to certify that to best of my knowledge I am not pregnant, and the doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle: _____.

Print Name:_____

Signature:_____

Guardian:_____

Informed Consent for Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for the patient and doctor(s) to be working on the same objective. It is important that each patient understands the objectives and the methods that will be used to attain the results, this will prevent any confusion or disappointment. You as a patient have the right to be informed of treatments and advised of the known benefits, risks and alternatives.

Medical treatments and/or procedures rendered by the provider will be thoroughly explained and discussed prior to treatment being performed; in regards to risks, benefits, and alternatives.

Chiropractic care has been proven to be very safe and effective. It is not unusual, however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer other side effects: i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

Physical therapy can be associated with certain risks such as; dizziness, falling risk, and soreness/tenderness. Any procedures conducted by the Physical Therapist will be discussed prior to being performed.

All questions regarding the doctor's objective to my care in this office have been answered to my complete satisfaction. The benefits, risk and alternatives of all treatments have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept all treatments, procedures, and therapies on this basis.

_____

Print Name

_____

Signature Date

Consent to Evaluate and Adjust Minor Child.

I,_____being the parent or legal guardian of _____ have read and fully understand the above informed consent and hereby grant permission for my child to receive any and all treatments deemed necessary.

Guardian's Name:_____DOB:_____

Guardian's Address:_____Same as Patient:▢

Guardian's Phone:_____

Relationship to Patient:_____

_____

Signature Date