**Patient Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_/\_\_/\_\_\_\_\_ **Gender**: M / F

**Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_ Zip:\_\_\_\_\_\_\_\_

**Preferred Phone**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Receive appointment reminders and quarterly  E-Newsletter via E-mail?   Yes / No thanks

**Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Race:** White / African American / Asian / American Indian or Alaska Native / Native Hawaiian / Pacific Islander / Other / Decline to Answer

**Ethnicity**: Non-Hispanic /  Hispanic/Latino /  Decline to Answer

**Smoking Status**: Never Smoked / Every Day Smoker / Occasional Smoker / Former Smoker

**Please List any medications you are currently taking:**

|  |  |
| --- | --- |
| Medication Name | Dosage and Frequency (i.e. 5 mg once a day, etc.) |
|  |  |
|  |  |
|  |  |
|  |  |

O *Mark here and list additional medications on the back of the page, if necessary.*

**Do you have any medication allergies?**

|  |  |  |
| --- | --- | --- |
| Medication Name | Reaction | Onset Date |
|  |  |  |
|  |  |  |

**Emergency Contact**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship**:\_\_\_\_\_\_\_\_ **Phone:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Doctor Name and Location**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Is your complaint related to an auto or workplace accident?**    Yes / No

List any surgical procedures and dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any accidents or traumas and dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any hospitalizations/major illnesses and dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Females only – Are you pregnant?  Y / N / Maybe      Date of last menstrual period: \_\_\_/\_\_\_/\_\_\_

**Please mark any of the following conditions/symptoms that you now or recently experienced:**

O Cancer        O Neck Pain            O Chest Pains            O Lights Bother Eyes

O High Blood Pressure    O Pain in Hands or Arms        O Shoulder Pain            O Dizziness

O Heart Attack        O Numbness in Hands or Arms   O Shortness of Breath        O Loss of Balance

O Stroke            O Low Back Pain            O Cold Hands/Feet        O Loss of Memory

O Diabetes      O Pain in Legs or Feet        O Fever                 O Loss of Smell or Taste

O Asthma        O Numbness in Legs or Feet    O Neck Stiff            O Ringing in Ears

O Allergies      O Pain between shoulder blades    O Sleeping Problems        O Tension/Irritability

O Menopause        O Joint Swelling            O Unexplained Weight Loss O Stomach Upset

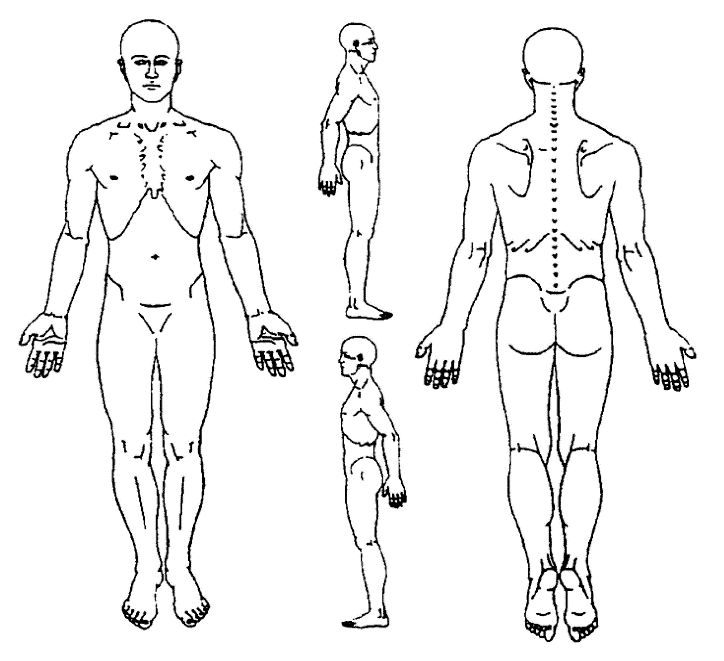
O Menstrual Cramps    O Jaw/TMJ Problems        O Fatigue            O Diarrhea

O Depression/Anxiety      O Painful Urination        O Constipation

O Heartburn/Reflux           O Discolored Urine

**O Other Medical Conditions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DOB \_\_/\_\_/\_\_\_\_ File# \_\_\_\_\_\_\_\_\_\_



**Using the symbols below, mark the area(s) of your complaint:**

    Dull Ache OOO

    Burning     XXX

    Sharp/Stabbing   / / /

    Tingling   + + +

    Numbness   = = =

    Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_  ^ ^ ^

**Please Indicate your pain level:**

**Currently**:

(No Pain) 0  1  2  3  4  5  6  7  8  9  10 (Worst Possible Pain)

**At worst**:

(No Pain) 0  1  2  3  4  5  6  7  8  9  10 (Worst Possible Pain)

**Average:**(No Pain) 0  1  2  3  4  5  6  7  8  9  10 (Worst Possible Pain)

**Release of Information/Authorization**

I authorize Ionia Family Chiropractic to release any medical or other information necessary to process insurance claims on my behalf. I also request payment of government or private benefits either to myself or to Ionia Family Chiropractic. This is a permanent authorization that I may revoke at any time by written notice.

**Patient Responsibility  Statement**

I certify that the information I provided is correct and understand it is my responsibility to inform this office of any changes in my health. I understand that I shall be personally financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my contract with my insurance provider. I agree to allow this office to examine me for further evaluation.

**Statement of Disclosure of HIPAA Practices**  
Your privacy is important to us! We will do everything that we can to ensure your health information is kept secure and private. A copy of our policies and procedures concerning the protection of your health information is available upon request.

I am aware that a copy of Ionia Family Chiropractic’s HIPAA policies and procedures is available on request.

**I choose to decline receipt of my clinical summary after visits**: (*Please ask the front desk for an explanation, if necessary)*Agree  /   No,  I'd like my summaries: printed / emailed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Legal Guardian Signature                  Date            Legal Guardian Name