

Welcome

NEW PATIENT HEALTH HISTORY

Date: _____

Patient Data

First Name _____ Last Name _____ Email _____

- Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

Mailing Address

Address _____ City _____ State _____ Zip _____

Phone (cell) _____ (home) _____ (work) _____

Preferred Phone: Cell Home Work Birth Date ____/____/____ Age _____

Gender: Male Female Marital Status: Married Single Widowed Divorced Separated

Name of spouse: _____ Spouse employed at _____ Ages of Children _____

Referred by: Friend Insurance Plan Gallagher Chiropractic Website
Google Yelp Facebook Other _____

Employer Data

Employer _____ Your Occupation _____

Brief description: _____

Your typical day: Sit at computer most of day Light manual labor Heavy manual labor Repeated motion

Emergency Contact Information

Name _____ Relationship to patient _____

Contact phone: _____ Alternative phone _____

Payment Information

Who is responsible for you bill? Self Spouse Health Insurance Employer Other _____

Health Insurance Company _____ ID # _____ Group # _____

If Auto Accident or Worker's Compensation

Name of Insurance Company _____ Claim number _____

Adjuster's name _____ Adjusters phone _____

Attorney's name _____ Attorney's phone _____

Patient Name: _____

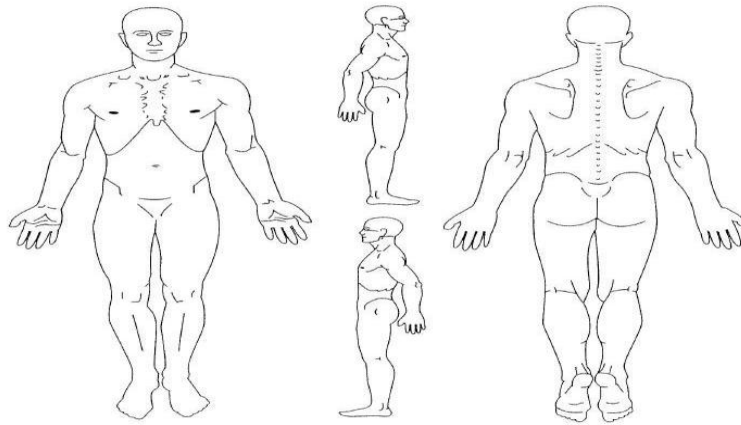
Date _____

Chief Complaint(s)

Describe your symptoms in order of severity, with worse symptom being #1:

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

- A = Ache
- S = Sharp
- B = Burning
- N = Numbness
- T = Tingling
- = Radiating



When did your symptoms begin? _____

How did your symptoms begin? _____

Are your symptoms the result of a: Motor vehicle accident Work related accident Other _____

Average Pain Intensity: (a range is ok)

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Last week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

How often do you experience your symptoms?

Constantly)

Frequently

Occasional

Intermittently

(76-100% of the day

(51-75% of the day)

(26-50% of the day)

(0-25% of the day)

What describes the nature of your symptoms?

Sharp Shooting Stabbing Dull ache Burning Numb Tingling Other _____

Are your symptoms? Getting better Staying the same Getting worse

What makes it better? Sitting Standing Lying Bending Twisting Lifting

Other _____

What makes it worse? Sitting Standing Lying Bending Twisting Lifting

Other _____

What have you done for it so far? _____

Have you experienced this problem or similar problem before? Yes No

If yes, please explain _____

Are you pregnant? Yes No N/A

Patient Name: _____

Date _____

HIPPA PRIVACY PRACTICES

I acknowledge that I have received and / or have been given the opportunity to review Gallagher Chiropractic's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient/Parent/Guardian Signature: _____ Date _____

FINANCIAL POLICY

I understand and agree that health and accident insurance policies are an agreement between and insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient/Parent/Guardian Signature: _____ Date _____

CONSENT TO TREAT MINOR

I _____ hereby authorize Dr. Richard Gallagher and whomever he may designate as chiropractic assistants to administer chiropractic care as deemed necessary to my son/daughter, _____ (minor's name).

Patient/Parent/Guardian Signature: _____ Date _____

HEALTH NEWSLETTER

Please sign me up for the monthly health newsletter. This is a short newsletter that you can customize to receive topics of your interest. Of course, you can cancel the newsletter at any time. Check the topics you are interested in:

___ Stress Management ___ Children's Health ___ Women's Health ___ Exercise and Fitness ___ Diet and Nutrition

___ Wellness Topics ___ Neck Pain and Headaches ___ Backaches and Sciatica ___ Doctor's Announcements

Patient/Parent/Guardian Signature: _____ Date _____

NOTIFICATION POLICY

I, hereby consent to have my physician, Dr. Richard Gallagher, and other staff at Gallagher Chiropractic to communicate with me by email, phone, and standard SMS/ text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and/or viewed by a third party.

I give my permission to have both appointments reminders and other private health information provided to me via phone, email, and standard SMS/text messaging.

Print Patient's Name _____

Patient/Parent/Guardian Signature: _____ Date _____