Case #____________

Brenham Chiropractic Clinic

"People should have their backs adjusted often--it would cut down on bad moods and ill tempers!" -K.S.

PATIENT INFORMATION FORM

Name: ____ Today's Date: ______________

Social Security Number: ____________________ Birth Date: __________ Age: _____ Gender: ❑F ❑M

If you are under 18 years of age, who are your legal parents or guardian ?

Father: ________________________ Date Of Birth: _________ Phone: __________________

Mother: ________________________ Date of Birth: _________ Phone: __________________

Guardian: ______________________ Date of Birth: _________ Phone: __________________

Who do you normally live with? ❑Mother and Father, ❑Father, ❑Mother, ❑Legal Guardian, ❑None of These

Marital Status: ❑Married, ❑Separated, ❑Widowed, ❑ Single Number of Children: ________________

Current Address: Street: ____

City: ______________________________ State: _______ Zip: ___________

Home Phone: ______________________ Cell Phone: __________________

e-mail address: ____

Other address where you reside (e.g. parent's home or any other address where you regularly reside)

Street: ______________________________ Phone: ____________________

City: ______________________ State: __________ Zip: _________

Your occupation: ________________________________ Employer: ______________________

Work Address: __________________________________ Work Phone: ____________________

Student at: __________________________ Full Time ❑ Part Time ❑ Work e-mail address:

Name Of Spouse: _______________________ Spouse's Date Of Birth: ________________________

Spouse's Occupation: ____________________ Spouse's Employer: __________________________

Spouse's Work Address: __________________________________ Work Phone: ________________

In case of an emergency whom should we contact? ______________________ Phone: _____________

Address of Contact Person: ____

How did you learn about us?

____

Did this condition result from an automobile accident ? ❑Yes, ❑No a work related cause? ❑Yes, ❑No

Please indicate any other healthcare provider you have seen for this injury or condition:

Name: ____ Type of Practice: ________________

Date of Last Visit: __________________ Date of last Physical Examination: ____________________

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Please describe and mark areas of pain or injury on the illustration. Give a very short description of the symptoms you are experiencing and rate the pain on the 0 (no pain) to 10 (Max pain) Scale

______________________________ 0 1 2 3 4 5 6 7 8 9 10

______________________________ 0 1 2 3 4 5 6 7 8 9 10

______________________________ 0 1 2 3 4 5 6 7 8 9 10

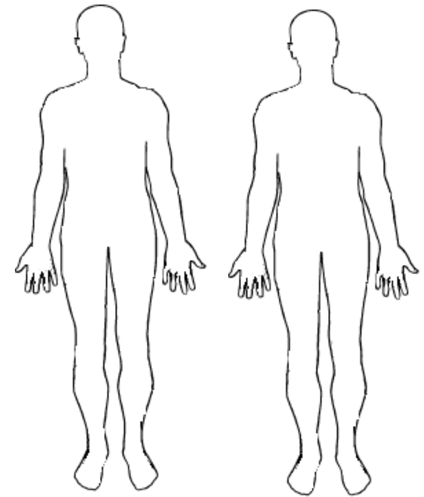
______________________________ 0 1 2 3 4 5 6 7 8 9 10

PLEASE MARK

Burning
Stabbing
Sharp
Dull

Constant
Comes & Goes

Tingling
Numbness



Have you ever had the same or similar condition? ______

If yes, please describe: ___________________________

____

____

Have you been treated for any other health condition by a physician in the last year? ______________________

Describe:____

Women Only: Are you pregnant or is there a possibility that you may be pregnant? ❑ Yes, ❑ No

Do you have health insurance? ❑ Yes, ❑ No If yes please provide insurance card or complete the following:

Company: _________________________ Policy number_____________________ Phone no:_____________

Full Name of Policyholder: _________________________________ Date of Birth: ______________________

Does the policyholder have this insurance through his or her employer? ❑ Yes, ❑ No

If yes, who is the employer?

Patient Consent Form: *Required by Federal Law*

I understand that some of my health information may be used and/or disclosed by Brenham Chiropractic Clinic (“your practice”) to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures, I should refer to your privacy notice entitled, “Our Privacy Practices.” I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time your privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call your office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this consent in writing, but only to the extent that your practice has not taken action in reliance thereon.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

I authorize this office to release any medical information relating to my treatment to any insurance company which may be responsible for paying benefits to me, and to my attorney who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the forgoing. The information I have provided is true and complete to the best of my knowledge.

Patient’s Signature: ____ Date: ________________

Name:________________________________ **5** Case No. _________