CONTINENTAL NATURAL HEALTH CLINIC

PATIENT INFORMATION

Name: _____ Birthdate: _____

Sex: M / F Spouse Name (if applicable): _____

Occupation: _____ Employed by: _____

Patient Address _____ City _____ St _____ Zip _____

Mailing Address _____ City _____ St _____ Zip _____

Home Phone: _____ Cell: _____ Work Phone: _____

Emergency Contact _____ Relationship: _____Phone : _____

NOTICE OF PRIVACY PRACTICES

We are concerned about protecting the privacy of our patients, and will use our best efforts to safeguard your protected information. Continental Natural Health Clinic collects information from you as required for your treatment, for our business operation, and as may be pursuant to regulatory requirements. Without it, we cannot provide our services. This information we collect is referred to as "protected information" and is used by our office only to carry out our duties in assisting you with health care operations. It is our policy not to disclose any protected information about our patients to anyone, except as necessary in the normal course of treatment, payment or business operations without your valid authorization. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations.

AUTHORIZATION TO RELEASE INFORMATION

I am authorizing you to release any information you feel appropriate concerning my condition to any insurance company, attorney or adjuster in order to receive reimbursement on any charges incurred.

AUTHORIZATION TO PAY DIRECTLY TO DOCTOR

I authorize the direct payment to you of any sum I now or hereafter owe you from any insurance company that is obligated to reimburse me for charges incurred in your office in part or in full or my attorney out of the proceeds of my settlement.

If you have any questions regarding this notice, please feel free to ask.

Signature of Patient: _____ Date: _____

CONTINENTAL CHIROPRACTIC

PATIENT HISTORY

Patient Name: _____ Date: _____

Describe your current problem and how it began:

_____

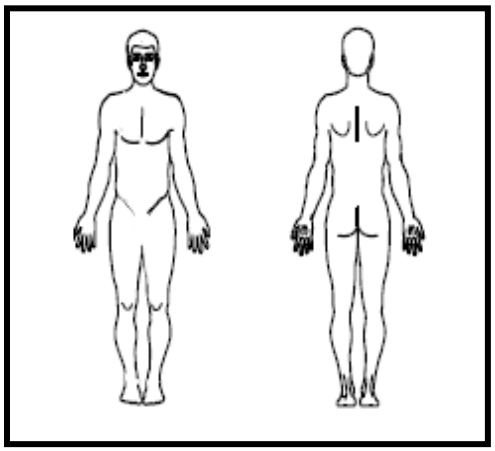
_____

_____

_____

When did this problem begin: _____

Mark an "X" on the picture where you have pain or other symptoms



Rate your pain today:

0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable Pain

How often are your symptoms present?
0-25% 26-50% 51-75% 76-100%

Can you perform your daily activities? Yes No
If no, please describe _____

Have you had spinal X-RAYS, MRI, CT SCAN? NO YES Dates taken _____
What areas were taken? _____

Please check all of the following that apply to you:

	Condition		Condition
_____	History of Recent Infection	_____	Prostate Problems
_____	Recent Fever	_____	Frequent Urination
_____	Headaches	_____	Urinary Retention
_____	Diabetes	_____	Abnormal Weight Gain or Loss
_____	High Blood Pressure	_____	Epilepsy / Seizures
_____	Stroke (date) _____	_____	Visual Disturbances
_____	Aortic Aneurysm (date) _____	_____	Dizziness / Fainting
_____	Arthritis	_____	Numbness in Groin / Buttocks
_____	Cancer / Tumor (date) _____	_____	Recent Trauma (date) _____
_____	Osteoporosis	_____	Pacemaker
_____	Pregnancy, # of births _____		
_____	Corticosteroid Use		

_____ Other major illnesses NOT listed above: _____

_____

_____

_____

CONTINENTAL CHIROPRACTIC

NAME : _____ DATE: _____

MEDICATIONS	Date Started (approx)	Dosage	Frequency

ALLERGIES	Reaction	Date (approx)

SURGERIES	Date (approx)	Results

CURRENT INFORMATION		
HEIGHT:	WEIGHT:	BLOOD PRESSURE:

SMOKING STATUS		
☐ NON-SMOKER	☐ FORMER SMOKER	☐ CURRENT SMOKER
	HOW LONG?	HOW MUCH?

FAMILY HISTORY (Check ALL that apply)			Deceased	Cause of Death
Mother	☐ Cancer ☐ Diabetes	☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke	☐ Yes ☐ No	
Father	☐ Cancer ☐ Diabetes	☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke	☐ Yes ☐ No	
Any other diseases that run in the family?				