PITTS
FAMILY & SPORTS
CHIROPRACTIC CENTER, P.C.

FOR OFFICE USE ONLY
PATIENT # _____
PHYSICIAN SIGNATURE _____
DATE _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Social Security # _____
E-mail Address: _____ Race: _____ Marital Status: ☐M ☐S ☐W ☐D
Occupation: _____ Employer: _____
Employer's Address: _____
Spouse: _____ Occupation: _____ Spouse's Employer: _____
Emegency Contact: _____ Phone: _____
How were you referred to our office? _____
Family Medical Doctor: _____
When Doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐Yes ☐No
Please check all insurance coverage that may be applicable in this case:
☐Major Medical ☐Worker's Compensation ☐Medicaid ☐Medicare ☐Auto Accident
☐Medical Savings Account / Flex Plans ☐Other
Name of Primary Insurance Company: _____
Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of (18%).

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient Signature: _____ Date: _____

Guardian Signature Authorizing Care: _____ Date: _____

HISTORY OF PRESENT AND PAST ILLNESS

Chief Complaint/Purpose of this appointment: _____
Date symptoms appeared or accident happened: _____
Is this due to: ☐ Auto ☐ Work ☐ Other
Days lost from work: _____
If this is a recurrence, when was the first time you noticed this problem? _____
How did it originally occur? _____
Has it become worse recently? ☐ Yes ☐ No ☐ Same ☐ Better ☐ Gradually Worse
If yes when and how? _____
How frequent is the condition? ☐ Constant ☐ Daily ☐ Intermittent ☐ Night Only
How long does it last? ☐ All Day ☐ Few Hours ☐ Minutes
Describe the pain: ☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing ☐ Other _____
What makes the problem worse? ☐ Standing ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting ☐ Other _____
Is there anything you can do to relieve the problem? ☐ Yes ☐ No
If yes, describe: _____
If no, what have you tried to do that has not helped? _____
Other Doctors seen for this condition: _____
Are there any other conditions or symptoms that may be related to your major symptom? ☐ Yes ☐ No
If yes, describe: _____
Are there other unrelated health problems? ☐ Yes ☐ No
If yes, describe: _____
Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No
If yes, describe: _____
Date of last physical examination: _____
Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (including dates): _____

_____

Have you had any broken bones? ☐ Yes ☐ No
If yes, please list and give dates: _____
Do you have a history of stroke or hypertension? ☐ Yes ☐ No
Do you have any allergies to any medications? ☐ Yes ☐ No
If yes, describe: _____
Do you have any allergies of any kind? ☐ Yes ☐ No
If yes describe: _____
Do you have any Congenital Conditions? ☐ Yes ☐ No
If yes, describe: _____
What Medications are you taking: _____
WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ Yes ☐ No ☐ Uncertain

NO SYMPTOMS — EXTREME SYMPTOMS

Please place an "X" on the line above to indicate level of chief complaint.