Collins Chiropractic, P.C.

Patient Information

Name: _____ **DOB:** _____

Address: _____ **Age:** _____

City: _____ **State:** _____ **Zip Code:** _____

Best Phone Number: **H C W** ***Please circle one***

Home: _____ **Occupation:** _____

Cell: _____

Work: _____ **Primary Care Doctor:** _____

If a Dependent, Person Responsible for Bill: _____ **Referred here by:** _____

Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other**

Name: _____ **DOB:** _____

Address: _____

Have you had previous chiropractic care? ☐ **Yes** ☐ **No**

How do you feel today? _____

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

Main Complaint: _____

Other Complaints: _____

How long have you had this condition? _____

Is this condition due to a work related injury? ☐ **Yes** ☐ **No** **An auto accident?** ☐ **Yes** ☐ **No**

Have you had similar conditions in the past? _____

What aggravates this condition? _____

What helps your symptoms? _____

Other Doctors seen for this condition? _____

Have you had any surgery, falls or accidents? ☐ **Yes** ☐ **No** **If yes, where?** _____

Please describe: _____

Current Medications: _____

Please circle any of the following that you suffer from:

Headaches	*Neck Pain*	*Arm/Shoulder Pain*	*Hip/Leg Pain*	*Chest Pain*	*Abdominal Pain*
Heart Trouble	*Palpitations*	*Poor Circulation*	*High Blood Pressure*	*Low Blood Pressure*	*Female Problems*
Kidney Trouble	*Bladder Problem*	*Sinus Trouble*	*Diabetes*	*Insomnia*	*Lung/Bronchial Disorder*
Digestive Disorder	*Constipation*	*Loose Stools*	*Anemia*	*Dizziness*	*Numbness*
Depression	*General Fatigue*	*Morning Fatigue*	*Poor Memory*	*Hot Flashes*	*Swollen Joints*

I _____ hereby voluntarily consent to treatment as it pertains to myself or _____, and the provision of care by the practitioners of this medical office. I have received and read a copy of this practices HIPPA policies. I certify that I have had the opportunity to discuss my care and the nature of the care and the nature of the care being provided to me. I understand that the results are not guaranteed. Further, I have been informed and that I understand that, as in any practice of the healing arts, in the practice of Chiropractic care, there are some risks to treatment. Including, but not limited to; fractures, disc injuries, dislocations and sprains. I also understand that Dr. Michael Collins is not expected to be able to anticipate and explain all of the potential risks and complications. I will rely on Dr. Michael Collins to exercise appropriate judgement during the course of my care based upon the facts known at the time and in my best interest.

My signature below certifies that I have read this statement.

Date:_____ **Signature:**_____ **Relationship:**_____

I authorize the release of any medical information necessary to process insurance claims, and the release of information back to my physician. I also authorize payment of medical benefits to the above stated practice or supplier for services rendered. I acknowledge that I am financially responsible for payment whether or not my insurance company covers services.

Signed: _____ **Date:** _____