Date________________

Home Phone________________________
Work Phone________________________
Cell Phone__________________________

Patient Information

Name____ SSN_________________________
First Last Middle Initial

Address____ City________________ State______ Zip____________

Sex (circle one) Male Female Age____ Birthdate__________ Marital status (circle one) Single Married Widowed Separated Divorced

Employer____ Occupation___________________________

Email Address ____

In case of emergency, who should be notified?_________________________________ Phone___________________

Primary Insurance

Insured name____ SSN_________________________
First Last MI

Relation to patient (circle one) Self Spouse Child Other Birthdate_______________ Phone___________________

Address (If different from patient's)__________________________________ City___________ State_____ Zip_______

Insured's employer____

Insurance Company____

ID#__________________________ Group#_________________________

Additional Insurance

Is patient covered by additional insurance? (circle one) Yes No

Insured name____ SSN________________________
First Last MI

Relation to patient (circle one) Self Spouse Child Other Birthdate_______________ Phone___________________

Address (If different from patient's)__________________________________ City___________ State_____ Zip_______

Insured's employer____

Insurance Company____

ID#__________________________ Group#_________________________

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:______________________________________ ________________________________ ______________
Responsible Party Relationship Date

Reason for Visit

Major complaint____

Other complaints____

Is this the result of an accident?(circle one) Yes No

If so, what kind of accident?(circle one) Auto Work Other Date of accident_______________________

Explain what happened____

____

____

Describe the pain. (circle one) Aching Burning Throbbing Stabbing Numbness Pins & Needles Other

Mark the location of the pain.

How long have you been having this pain?____

Is the condition getting worse?____

Is it constant? (circle one) Yes No Comes and goes? (circle one) Yes No

Is this condition interfering with your (circle one) Work? Sleep? Daily routine?

If so, please explain____

Have you had this or similar conditions in the past? (circle one) Yes No

When was the last time?____

Have you been treated by a Medical Physician for this condition? (circle one) Yes No

If so, who?____ Were medications prescribed? (circle one) Yes No

Please list____

Have you been seen by a Chiropractor before?(circle one) Yes No

If so, who?_______________________________ When?____

For what condition(s)?____

____

Medical History

Das verknüpfte Bild kann nicht angezeigt werden. Möglicherweise wurde die Datei verschoben, umbenannt oder gelöscht. Stellen Sie sicher, dass die Verknüpfung auf die korrekte Datei und den korrekten Speicherort zeigt.

Check any symptoms you currently have or have had in the past year.

___ Headaches	___ Buzzing in ears	___ Irritability	___ Diarrhea
___ Dizziness	___ Ringing in ears	___ Trouble sleeping	___ Urinary problem
___ Pins & Needles in arms	___ Fatigue	___ Tension	___ Mood Swings
___ Pins & Needles in legs	___ Depression	___ Fever	___ Loss of smell
___ Numbness in fingers	___ Constipation	___ Cold sweats	___ Loss of taste
___ Numbness in toes	___ Menstrual pain	___ Fainting	___ Back pain
___ Cold hands	___ Ulcers	___ Blurred/double vision	___ Neck pain
___ Cold feet	___ Hot flashes	___ Stomach upset	___ Stiff neck

Check any conditions you currently have or have had in the past year.

___ Heart attack/Stroke	___ HIV+/AIDS	___ High/Low blood pressure	___ Kidney problems
___ Heart surgery/Pacemaker	___ Hepatitis	___ Psychiatric problems	___ Sinus problems
___ Heart murmur	___ Shingles	___ Severe/Frequent headaches	___ Difficulty breathing
___ Congenital heart defect	___ Cancer	___ Kidney problems	___ Artificial joint/bones
___ Mitral Valve Prolapse	___ Frequent Neck Pain	___ Ulcers/Colitis	___ Asthma
___ Artificial valves	___ Emphysema	___ Fainting/Seizures	___ Chemotherapy
___ Alcohol/Drug abuse	___ Glaucoma	___ Diabetes	___ Arthritis
___ Venereal disease	___ Anemia	___ Lower back problems	

Please list any other serious medical conditions or diseases you currently have or have had in the last year
____
____

List any medications you are currently taking____
____

Please list anything that you may be allergic to____

List previous surgeries/treatments with dates____

List any past serious accidents with dates____

Do you smoke? (circle one) Yes No How much?________________________ How long?___________________

For Women:

Are you pregnant? Yes No How far along?__________ Are you nursing? Yes No Number of children_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

____ ________________________

Patient Signature Date

____ ________________________

Parent/Guardian Signature Date

Family History

Das verknüpfte Bild kann nicht angezeigt werden. Möglicherweise wurde die Datei verschoben, umbenannt oder gelöscht. Stellen Sie sicher, dass die Verknüpfung auf die korrekte Datei und den korrekten Speicherort zeigt.

Relation	**Age**	**State of Health**	**Age at Death**	**Cause of Death**
Father				
Mother				
Brother(s)				
Sister(s)				

Check if your blood relatives had any of the following:

	Disease	Relationship to You
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

Health Habits

Das verknüpfte Bild kann nicht angezeigt werden. Möglicherweise wurde die Datei verschoben, umbenannt oder gelöscht. Stellen Sie sicher, dass die Verknüpfung auf die korrekte Datei und den korrekten Speicherort zeigt.

Check which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational

Occupation: ___________________________________

Check if your work exposes you to the following:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? (circle one) Yes No
If yes, please give approximate dates ____

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications (if any)

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

____ _________________________

Patient Signature Date

____ _________________________

Parent/Guardian Signature Date

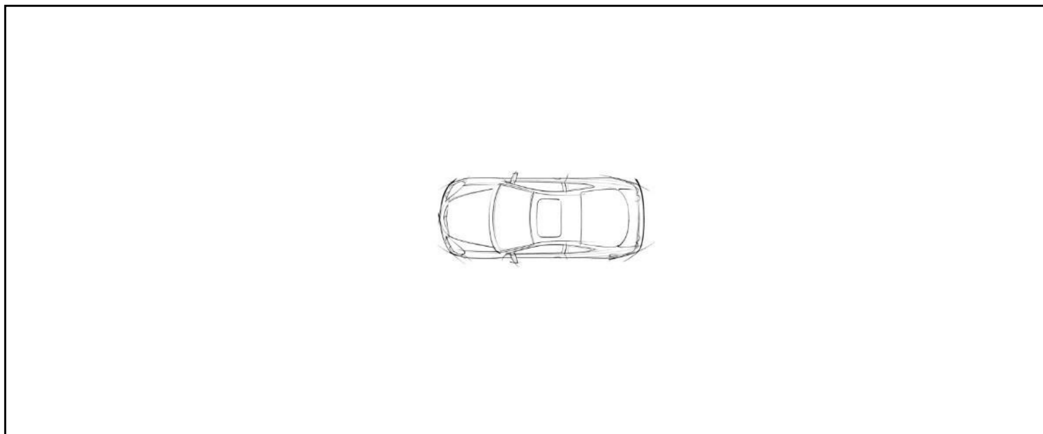
Accident History Questionnaire

Name ______________________________ Date ______________

1. Date of Accident: ______________________________ Time __________ AM/PM
2. Driver of Car: ______________________________
3. Where were you seated? ______________________________
4. Year & Model of your car: ______________________________
5. Year & Model of the other car: ______________________________
6. Visibility at the time of accident: ☐ poor ☐ fair ☐ good ☐ other: ______________
7. Road conditions at the time of the accident: ☐ icy ☐ rainy ☐ wet ☐ clear ☐ dark

   ☐ other (describe): ______________________________

8. Illustrate below how the accident happened:



In your own words, please describe the accident: ______________________________

____

____

____

9. Was your car braking at the time of the accident? ☐ yes ☐ no
10. Was your car moving at the time of the accident? ☐ yes ☐ no
11. If yes, how fast would you estimate you were going? __________ mph
12. How fast would you estimate the other car was going? __________ mph
13. Did you see the accident coming? ☐ yes ☐ no
14. Did you brace for the impact? ☐ yes ☐ no
15. Were seatbelts worn? ☐ yes ☐ no

16. Were shoulder harnesses worn? ☐ yes ☐ no
17. How was the shoulder harness adjusted? ☐ Loose ☐ Snug
18. Were you wearing a hat or glasses? ☐ yes ☐ no
19. Did your airbags deploy? ☐ yes ☐ no
20. Does your car have headrests? ☐ yes ☐ no
21. If yes, what was the position of those headrests compared to your head before the accident?

☐ Top of headrest even with the bottom on head
☐ Top of headrest even with the top of the head
☐ Top of headrest even with the middle of neck

22. Head/Body position at the time of impact:

☐ Head turned left/right ☐ Body straight in sitting position
☐ Head looking back ☐ Body rotated left/right
☐ Head straight forward ☐ Other: ______________________________

23. At the time of the accident, recall what parts of your head or body hit what parts on the inside of the car: ______________________________

24. Could you move all parts of your body? ☐ yes ☐ no
25. If no, what parts couldn't you move and why?

____

26. Were you able to get out of the car unaided? ☐ yes ☐ no
27. If no, why not? ______________________________
28. As a result of the accident, you were: ☐ Rendered unconscious ☐ In shock
☐ Dazed, circumstances vague ☐ Other: ______________________________
29. Did you have any bleeding cuts? ☐ yes ☐ no If yes, where? ________________
30. Did you have any bruises? ☐ yes ☐ no If yes, where? ________________
31. Please describe how you felt:

Immediately after the accident: ______________________________

Later that day: ______________________________

The next day: ______________________________

32. Check symptoms apparent since the accident:

☐ Headache	☐ Neck pain/stiffness	☐ Mid back pain
☐ Eyes light Sensitive	☐ Pain behind eye	☐ Dizziness
☐ Fainting	☐ Sleeping problems	☐ Numbness in fingers
☐ Numbness in toes	☐ Loss of smell	☐ Loss of taste
☐ Loss of memory	☐ Fatigue	☐ Shortness of breath
☐ Irritability	☐ Depression	☐ Ringing/buzzing
☐ Loss of balance	☐ Tension	☐ Cold hands
☐ Cold feet	☐ Diarrhea	☐ Constipation
☐ Chest pain	☐ Nervousness	☐ Cold sweats
☐ Anxious	☐ Facial Pain	☐ Clicking/popping jaw
☐ Low back pain	☐ Other: ________________________________	

33. Did you receive any medical attention at the scene of the accident? ☐ yes ☐ no

34. If yes, what type of treatment did you receive? ________________________________

____

35. Did you seek medical help immediately after the accident? ☐ yes ☐ no

36. If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Someone else drove me

☐ Drove own car ☐ Other: ________________________________

37. **Doctor #1**: Name: ________________________________

38. First visit date: ________________________________

39. Were you examined? ☐ yes ☐ no

40. Were X-Rays taken? ☐ yes ☐ no

41. Did you receive treatment? ☐ yes ☐ no

42. If yes, what type of treatment did you received? ☐ Medications ☐ Brace

☐ Collar ☐ Other: ________________________________

43. What benefits did you receive from the treatment? ________________________________

44. Date of last treatment: ________________________________

45. **Doctor #2**: Name: ________________________________

46. First visit date: ________________________________

47. Were you examined? ☐ yes ☐ no

48. Were X-Rays taken? ☐ yes ☐ no

49. Did you receive treatment? ☐ yes ☐ no

50. If yes, what type of treatment did you received? ☐ Medications ☐ Brace
☐ Collar ☐ Other: ____________________

51. What benefits did you receive from the treatment? ____________________

52. Date of last treatment: ____________________

53. Have you missed time from work? ☐ yes ☐ no

54. If yes, full-time off work: ______________ to ______________

55. If yes, part-time off work: ______________ to ______________

56. Past Medical History:
☐ None related to current complaints ☐ Hospital or Operation ☐ Auto accident
☐ Work accident ☐ Illness ☐ Other: ____________________

57. Family History:

☐ Tuberculosis	☐ Kidney Disease	☐ Spinal Disorder
☐ Mental Illness	☐ Epilepsy	☐ Diabetes
☐ Gout	☐ Cancer	☐ Migraines
☐ Hypertension	☐ Heart Attack	☐ Other: ______________

58. Personal History:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/Widower

Number of Children: ____________________

Number of Children at home: ____________________

59. Are you pregnant? ☐ yes ☐ no

60. List all medications you are currently taking: ____________________

____

____

Health and Medical Information Release Form

I, ______________________________, give permission to the staff, associates and employees of Circle City Chiropractic t share private and medical information with my medical doctors as well as his/her staff, employees and associates. Also, my medical doctors, as well as their staff, employees and associates have my permission to share personal and medical information with the staff, associates and employees of Circle City Chiropractic.

Signature:____ Date:_________________________________

Medical Doctor Information

Name of Doctor:____

Address: ____

City, State, Zip: ____

Phone: ____

Name of Doctor: ____

Address: ____

City, State, Zip: ____

Phone: ____

Name of Doctor: ____

Address: ____

City, State, Zip: ____

Phone: ____

SYSTEM REVIEW **Place an (X) next to the symptoms you know you have**

Genito-Urinary System

- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination

Gastro-Intestinal System

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting food
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoid
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Weight trouble

Nervous System

- ☐ Numbness
- ☐ Loss of Hearing
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscle jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression

Cardio Vascular System

- ☐ Chest Pain
- ☐ Pain over heart
- ☐ Difficulty breathing
- ☐ Persistent Cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ High blood pressure
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins
- ☐ Other

Eye, Ear, Nose, and Throat System

- ☐ Eye strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Hearing loss
- ☐ Nose discharge
- ☐ Sore mouth
- ☐ Speech difficulty

Activities of Daily Living Assessment

Directions: This questionnaire is designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check one item in each section which most closely applies to you.

SECTION 1 PAIN INTENSITY

- ☐ I can tolerate the pain I have without using painkillers.
- ☐ The pain is bad but I manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers give no relief from pain and I do not use them

SECTION 2 PERSONAL CARE (washing, dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

SECTION 3 LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 WALKING

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can only walk using a cane or crutches.
- ☐ I am in bed most of the time and have to craw to the toilet.

SECTION 5 SITTING

- ☐ I can sit in a chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than one hour.
- ☐ Pain prevents me from sitting for more than 30 minutes.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

SECTION 6 STANDING

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want, but it causes extra pain.
- ☐ Pain prevents me from standing for more than one hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

SECTION 7 SLEEPING

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 SEX LIFE

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal, but causes some extra pain.
- ☐ My sex life is nearly normal, but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

SECTION 9 SOCIAL LIFE

- ☐ My social life is normal and causes no extra pain.
- ☐ My social life is normal, but increases in the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, (dancing, etc.)
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

SECTION 10 TRAVELING

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere, but it gives me extra pain.
- ☐ Pain is bad, but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to short necessary trips under a half hour.
- ☐ Pain restricts from traveling except to the doctor or hospital.

Current Chief Complaint(s): Place an (X) in the appropriate complain areas.
Place an (X) in the appropriate complaint areas.

SPINE

☐ Low back	☐ Mid back	☐ Neck
☐ Pelvis		

UPPER EXTREMITY

☐ Shoulder R/L	☐ Arm R/L	☐ Elbow R/L
☐ Writs R/L	☐ Forearm R/L	☐ Hand R/L

LOWER EXTREMITY

☐ Hip R/L	☐ Thigh R/L	☐ Knee R/L
☐ Leg R/L	☐ Ankle R/L	☐ Foot R/L

OTHER (describe):____

Subjective Pain Level

On a scale of 1-10, place an (X) in your current pain level.

NORMAL
☐ 0
LOW PAIN
☐ 1 ☐ 2 ☐ 3
MODERATE PAIN
☐ 4 ☐ 5 ☐ 6
INTENSE PAIN
☐ 7 ☐ 8 ☐ 9
EMERGENCY
☐ 10

Mark the areas on your body where you Feel the described sensations. Use the appropriate symbol. Mark stress pints of radiation. Include all affected areas.

X NUMBNESS + BURNING
O PINS & NEEDLES + STABBING

____
Patients Signature

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Circle City Chiropractic, we may use or disclose personal and/or health related

information about you in the following ways:

- **Your personal health information, inclusive of your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment,**
- **Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, and HMO, a PPO, or your employer if they are or may be responsible for the payment of your services.**
- **Your name, address, phone number, and your healthcare records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.**

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing chiropractic care services to you based on the orders of another chiropractic care provider,
- If we provide health care services to you in an emergency,
- If we are required by law to provide care to you, and we are unable to obtain your consent after attempting to do so,
- If there are substantial barriers to communicating with you, but in our professional judgment, we believe that you intend for us to provide care, or
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than that outlined above, will be made only upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing of your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Tom Nottingham.

If you would like further information about our privacy policies and practices please contact Dr. Tom Nottingham.

This office uses and "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements can be made for you.

This notice is effective as of__________________________. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

________________________________ ________________________________ ____________________

Name (Printed please) Signature Date

If you are a minor or if another party is representing you, a signature is required by that person.

________________________________ ________________________________ ____________________

Personal Representative (Printed) Personal Representative Signature Date

____

Description of the authority to act on behalf of the patient.