PATIENT INFORMTION

Date______________________________

Patient Name______________________________

Address______________________________

City______________State________Zip__________

Sex ☐M ☐F Age_______ DOB______________

SSN______________________________

Home#_______________Work#______________

Cell #______________________________

☐Married ☐Widowed ☐Single ☐Separated ☐Divorced

☐Minor ☐Partnered for ____ years

Race: ☐Asian ☐Black ☐Hispanic ☐Indian ☐White

☐Other______________________________

Occupation______________________________

Employer/School______________________________

Employer/School Address______________________

____

Employer/School Phone______________________

Spouse's Name______________________________

DOB____________ SSN____________________

Spouse's Employer______________________________

IN CASE OF EMERGENCY, CONTACT

Name______________________________

Relationship__________Phone #______________

Who can we thank for referring you?

____

INSURANCE INFORMATION

Who is responsible for this account? ______________

Relationship to Patient______________________

Insurance Co.______________________________

Member ID______________Group#______________

Is patient covered by additional insurance? ☐Yes ☐No

Ins. Co.______________________________

Member ID______________Group #______________

ACCIDENT INFORMATION

Is condition due to an accident? ☐Yes ☐No

Type of accident ☐Auto ☐Work ☐Home

☐Other______________________________

To who have you made a report of your accident?

☐Auto Ins. ☐Employer ☐Worker Comp ☐Other

Date of Injury______________________________

Attorney Name______________________________

MRI/X-RAYS/CT SCANS

Have you had any imaging done? ☐Yes ☐No

If so, when and where?______________________

Have you seen anyone else for this condition? ☐Yes

☐No If so, whom and when?__________________

____

COMMUNICATION

Email Address______________________________

Would you like to receive our Newsletter? ☐Yes ☐No

How would you like to receive appointment reminders?

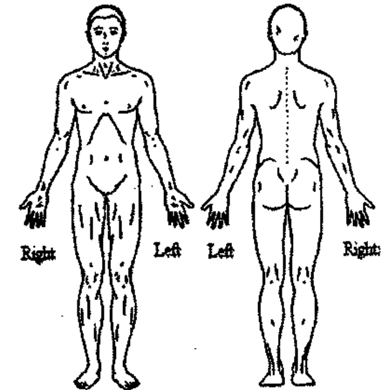
☐ Phone Call ☐Text Message ☐ Email

____

(Please provide carrier for text messages)

Patient Name______________________ ID#__________ Date________

PATIENT CONDITION



Please mark all problem areas.

Reason for Visit______________________________

When did you first notice the symptom(s)?______________

Is this condition getting progressively worse? □Yes □No

Where specifically is the problem(s) located?______________

Which activities are difficult to perform? □Sitting □Standing □Walking

□Bending □Lying down □Other__________

Type of pain : □Sharp □Dull □Throbbing □Numbness □Aching

□Shooting □Burning □Tingling □Cramps □ Stiffness □Swelling
□Other________________________

Rate the severity of your pain. (1-mild to 10-severe). 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go?________________________________

What treatment have you already received for your condition?______________________

Name and address of other doctor(s) who have treated you for your condition:

____

Health History

Indicate any of the conditions you currently have or had in the past

□AIDS/HIV	□Chemical Dependency	□Hepatitis	□Pacemaker	□Tumors, Growths
□Alcoholism	□Chicken Pox	□Hernia	□Parkinson's	□Ulcers
□Allergies	□Depression	□Herniated Disc	□Pinched Nerve	□Vaginal Infections
□Anemia	□Diabetes	□Herpes	□Pneumonia	□Whooping Cough
□Anorexia	□Emphysema	□High Blood Pressure	□Polio	□Other__________
□Appendicitis	□Epilepsy	□High Cholesterol	□Prostate Problems	__________
□Arthritis	□Fibromyalgia	□Kidney Disease	□Prosthesis	__________
□Bleeding Disorders	□Fractures	□Liver Disease	□Psychiatric Care	__________
□Breast Lump	□Glaucoma	□Measles	□Rheumatoid Arthritis	
□Bronchitis	□Goiter	□Migraine Headaches	□Stroke	
□Bulimia	□Gout	□Miscarriage	□Thyroid Problems	
□Cancer	□Heart Disease	□Multiple Sclerosis	□Tonsillitis	
□Cataracts		□Osteoporosis	□Tuberculosis	

Patient Name______________________ ID#__________ Date______________

Name of Primary Care Physician ______________________________________
Phone # ______________________ Date of Last Exam ______________________

Women: Are you pregnant? □Yes □No Nursing? □Yes □No Taking birth control pills? □Yes □No

Injuries/Surgeries you have had

	Description	Date
Accidents	______________________	________
Broken Bones	______________________	________
Surgeries	______________________	________
Hospitalizations	______________________	________

FAMILY HISTORY
Please tell us about the health of your parents, siblings and children. Check everything that applies. If someone is deceased, please write in the cause.

	Living/Deceased (cause of death)	Heart Disease	Stroke	Cancer	Diabetes	RA	MS	Lung Disease	Bone Disease
Father									
Mother									
Siblings									
Children									

EXERCISE
- □ None
- □ Moderate
- □ Daily
- □ Heavy

WORK ACTIVITY
- □ Sitting
- □ Standing
- □ Light Labor
- □ Heavy Labor

HABITS
- □ Smoking — Packs/Day______________
- □ Alcohol — Drinks/Week______________
- □ Coffee/Caffeine — Cups/Day______________
- □ High Stress Level — Reason______________

MEDICATIONS

____
____
____

Pharmacy Name______________
Phone #______________

ALLERGIES

____
____
____
____
____

VITAMINS/HERBS/MINERALS

____
____
____
____
____

I certify that the information provided is true and complete to the best of my knowledge.

______________________________ ______________________
Patient Signature Date

Cunningham Chiropractic

8827 N. Government Way #3
Hayden, ID 83835
(208)635-5658 Fax (208)635-5659

Authorization for Release/Request of Medical Information

To Whom It May Concern:
I hereby authorize the office of Wendy Cunningham, D.C. to request any medical records, x-rays, emergency reports, physician's reports, police reports, and/or other pertinent information pertaining to my case as necessary. I also hereby authorize the office of Wendy Cunningham, D.C. to release or furnish to any requesting hospital, physician, medical attendant, insurance company, or attorney, any and all medical information, including x-rays, pertaining to my case.
_____________(Patient's initials)

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me or on the patient named below, for whom I am legally responsible, by Wendy Cunningham, D.C.

I understand the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect Wendy Cunningham, D.C. to be able to anticipate and explain all of the risks and complications and wish to rely on the doctor to exercise judgment to act in my best interest during the course of treatment.

I have read and understand the above consent form and understand the risks of the recommended treatment. I understand and consent to the treatment being delivered by Dr. Wendy Cunningham. No guarantee or assurance of results has been made to me.____________________(Patient's initials)

I hereby certify that I have read and understand the contents of this form, and I have signed this document knowingly, freely and voluntarily. Moreover, I certify and state that I have received no promised assurances or guarantees from anyone as to the results that may be obtained by any treatment or services.

____ ________________
Patient/Parent/Guardian Signature **Date**

____ ________________
Witness **Date**

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(208)635-5658 Fax(208)635-5659

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with

____
NAME OF INSURANCE COMPANY (IES)

and assign directly to Dr. Wendy Cunningham all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Wendy Cunningham may use my health care information and may disclose such information to the above-named insurance company (or companies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ _______________
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE DATE

____ _______________
PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, ____
PRINT PATIENT NAME

Have received a copy of **Cunningham Chiropractic's Notice of Privacy Practices.**

____ _______________
PATIENT SIGNATURE DATE

For Minors:

____ _______________
PATIENT NAME DOB

____ _______________
SIGNATURE OF GUARDIAN DATE