Red Rock
Chiropractic & Wellness Center

Patient

Name:_____
Last First M.I.
Nick Name: _____
Address: _____
_____
City State Zip
Sex: M / F Age:_____ DOB:_____
Married Status Single_____ Married_____ Other_____
Email:_____
Patient SSN:_____
Home Phone:_____
Cell:_____
Contact Method (Pick One)
Home :_____ Cell:_____ Email :_____
Work:_____ FT PT
Occupation:_____
Employer:_____
Whom may we thank for referring you:
_____
Verification Question (*Pick One*) For Security Reasons
Name of pet?_____ City born in?_____
High School?_____ Mother's maiden name_____
Anniversary date_____

Insurance

Insurance Type: BCBS United Medicare Medicaid _____
Policy Holder:_____
Relationship to Holder:_____
DOB :_____
Policy Number:_____ **Group Number**:_____
Employment _____

Financial Policy

1) We accept the following forms of payment: cash, checks, debt/credit cards.
2) Full payment for your responsible portion of services is expected at the time of your visit.
3) Please feel free to ask any financial questions you may have.
4) All no-shows appointments will be assessed a $25 cash fee at your next visit.
5) I have read and understand the Financial Policy of Red Rock Chiropractic and I authorize them to submit insurance claims on my behalf (if applicable). I also hereby instruct and direct the payment of all professional expense benefits allowable and otherwise payable to me under my current policy to Red Rock Chiropractic as payment for services rendered. I have agreed to pay, in a current manner, any balance of said service charges over and above insurance payments. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case. I authorize the use of this signature on all insurance submissions.

WELCOME

In Case of Emergency, Contact:

Name:_____
Phone:_____
Relation:_____

Parent (If patient is a minor)

I hereby request and authorize Dr Ryle Smith DC to perform diagnostic tests, render chiropractic adjustments, and other treatments to MY MINOR CHILD_____.
This authorization also extends to all other doctors and office staff members and is intended to include radiographic examinations at the doctor discretion.
As of this date, I have the legal right to select and authorize health care services for the minor child named above.

_____ _____
Signature Date

_____ _____
Print Name Witness

_____
Relationship to Patient

Doctors

Have you been to a Doctor of Chiropractic before?
Yes No
Name:_____
Clinic Doctor
Last date of visit:_____
Family Medical Doctor:_____

Accident Information

Is this condition due to an accident? YES NO
Date of Accident:_____ **Type**:_____
To Whom have you made a report of your accident?
(Circle One) Auto Employer Other
Insurance Name:_____
Claim Number:_____
Contact Name:_____

Signature

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I authorize the Doctor and staff to perform any necessary service that I may need during diagnosis and treatment with m informed consent.

_____
Responsible Party Signature

Patient History (Please include dates)

Accidents:_____
Surgeries:_____
Medications (Including Dosages): **Check if no medications are currently taken:_____**
1)_____ 2)_____
3)_____ 4)_____
5)_____ 6)_____
7)_____ 8)_____
List current known allergies that you have to any medications: **Check if no allergies are known:_____**
1)_____ 2)_____
3)_____ 4)_____

Has any Doctor Diagnosed you with Hypertension presently? YES_____ NO_____ IF yes, what type_____
H**as any Doctor Diagnosed you with Diabetes presently?** YES_____ NO_____ IF yes Type I or Type II
If yes to Diabetes, was your blood work test for Hemoglobing A1c > 9.0 % YES_____ NO_____
Has any Doctor Diagnosed you with any type of significant health syndrome presently? YES_____ NO_____
IF yes, What kind?_____
Have you had an X-ray or CT scan or MRI of you LOW BACK SPINE within the past 28 days? YES___ NO___
Hospitalizations:_____

Are you Pregnant? YES NO **Week Number**:_____ **Nursing**?: YES NO

Do you Smoke? YES_____ Never smoked_____ Former smoker_____
Number of packs a day_____
IF yes, What is your level of interest in quitting smoking? 1 2 3 4 5 6 7 8 9 10

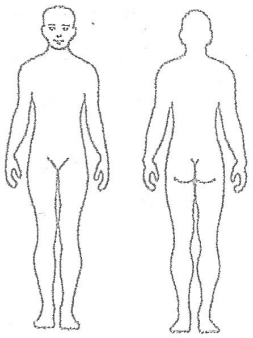
Height:_____ **Weight**:_____ **Blood Pressure**:_____

Race/Ethnicity:
White:_____ African American:_____ Hispanic:_____ America Indian:_____ I chose not to specify:_____

Multi-Racial Yes No I chose not to specify
Preferred Language:_____

Present Condition

Present Condition:_____
Where exactly is the problem?_____
When did the problem Begin?_____
Have you experienced this before? YES NO **When**?_____ **Treatment provided**?_____
Type of injury?_____ **How did you injure yourself**?_____
Describe the pain_____ **Is it getting Worse?**
YES NO
Constant or Comes and Goes **How often do you have this pain**_____
Rate the Pain 1 2 3 4 5 6 7 8 9 10 SEVERE
Please mark on the human figure where your pain is located.



Type of pain:
Sharp Dull Throbbing Numbness
Arching Shooting Burning Tingling
Cramping Swelling Other_____
Does it interfere with your:
Work Sleep Daily Routine Recreation
Activities of movements that are painful to perform:
Sitting Standing Walking Bending Lying Lifting
Twisting Coughing Sneezing Sleeping Moving Breathing
Check all symptoms that you are experiencing or have experienced even if they seem unrelated to your condition:

Headache	Nervousness	Fainting	Menstrual pain	Back pain
Dizziness	Tension	Cold Hands	Hot flashes	Menstrual irregularity
Fatigue	Loss of smell	Heartburn	Numbness in legs	Stiff neck