INTRODUCTION PATIENT CASE HISTORY

Name: (First MI Leat) Name: (First MI Leat) Address: City:								
Date of Birth: Gender: Male Female Social Security #: Work: Work: Work: Work: Primary Primary Primary Other: Primary Other: Ot								
Home: Mobile: Work: Work: Email Phone - Home, Mobile, or Work Other: Preferred Method of Contact: Text Email Phone - Home, Mobile, or Work Other: Preferred By: (Name) Preferred By: (Name) Other: Preferred By: (Name) Preferred Language: English African American or Black English Spanish Asian Other: Spanish Asian Other: Decline White Decline White Decline White Decline White Decline White Decline Mobile: Doctor's Phone: Primary Care Physician: Doctor's Phone: Standard Standa	Address:		City		Preferred N	Preferred Name:		
Email:	Date of Birth:	Gender: Male	☐ Female	Social C	State:	Zip:		
Email: Preferred Method of Contact:	Home:	Mobile:	- Temale					
Preferred Method of Contact:	Email:			work:				
*Referred By: (Name) Family Friend Co-Worker Doctor Other: Race & Ethnicity: (Choose up to 2) Preferred Language: African American or Black English Asian Other: Other: Hispanic or Latino Decline Native Hawaiian or Other Pacific Islander White Decline Decline BERGENCY CONTACT INFORMATION Name: (First MI Last) Primary Care Physician: Doctor's Phone: Child Parent Spouse Other: Other: Doctor's Phone: Asian Other: Doctor's Phone: Spanish Doctor's Phone: Other: Doctor's Phone: Other: Doctor's Phone: Address: Dother (Details below) Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Data Da	Preferred Method of Contac	t: Text Fi	nail [] P	none II Mari				
Race & Ethnicity: (Choose up to 2) African American or Black	*Referred Ry: Name			Hone - 110me, Mobile, or Wo	ork Oth	er:		
Race & Ethnicity: (Choose up to 2)	☐ Family ☐ Friend	☐ Co-Worker ☐	Doctor	Other:				
African American or Black	the same for the first term one for the fact that the first term (to	n		and the last last last last last last last last	me my fine and con that has not me they are			
American Indian or Alaskan Native				inguage:				
Asian			225					
Native Hawaiian or Other Pacific Islander White Decline Decline Primary Care Physician: Doctor's Phone: Doctor's Phone: Child Parent Spouse Other: No Auto Work Other: Self Other (Details below) Self Other (Details below) Primary: ID#; Address: Phone: Email: Phone: Email:								
Native Hawaiian or Other Pacific Islander White Decline	☐ Hispanic or Latino							
White Decline		Pacific Islander	Decline					
Primary Care Physician: Doctor's Phone:		1 define Islander						
Primary Care Physician: Doctor's Phone: Doctor's Phone:								
Relationship: Child Parent Spouse Other: Where would you like statements sent? No Auto Work Other: Self Other (Details below) Name: Primary: D#: Home: Email:	TValle. (First MI Last)	Makila		Primary Care Physic	ian:			
today's visit the result of an accident? No Auto Work Other: Self Other (Details below) Where would you like statements sent? Self Other (Details below) Name:	Home:	Mobile:						
today's visit the result of an accident? No Auto Work Other: Self Other (Details below) Where would you like statements sent? Self Other (Details below) Name:	Home:	Modife:	The same of the sa	Boctor's I none:				
today's visit the result of an accident? No Auto Work Other: Self Other (Details below) Vill we be working with insurance? No Yes (Details) Primary: ID#: Phone: Email:	Home: Relationship: ☐ Child ☐ Parent ☐ Spou	use 🗆 Other:						
□ No □ Auto □ Work □ Other: □ □ Self □ Other (Details below) No □ Yes (Details) Name: □	Home:Relationship: Child Parent Spou	use 🗆 Other:						
Name:	Home:	ise						
Primary: ID#: Address:	Home:	se		Where would you like	e statements se			
condary: ID#: Phone: Email:	Home: Relationship: Child Parent Spou	se		Where would you like ☐ Self ☐ Other (e statements se	ent?		
	Home:	nccident? rk	es (Details)	Where would you like ☐ Self ☐ Other (Name:	e statements se Details below)	ent?		
	Home:	ise Other: iccident? rk Other: nce? No Ye	es (Details)	Where would you like ☐ Self ☐ Other (Name: Address:	e statements se Details below)	ent?		
	Home:	ise Other: iccident? rk Other: nce? No Ye	es (Details)	Where would you like ☐ Self ☐ Other (Name: Address:	e statements se Details below)	ent?		
have answered these questions to the best of my knowledge and certify them to be true and correct.	Home:	accident? rk	es (Details)	Where would you like ☐ Self ☐ Other (Name:	e statements se Details below) Email:	ent?		
atient or Guardian Signature Date	Relationship: Child Parent Spou ANCIAL INFORMATION today's visit the result of an a No Auto Working with insuran Primary: condary:	nccident? rk	es (Details)	Where would you like ☐ Self ☐ Other (Name: Address: Phone:	e statements se Details below) Email:	ent?		

© Seamless, LLC SEAMLESS™EHR
Page 1 of 1

HISTORY OF PRESENT ILLNESS

Major Complaint:	Secondary (Secondary Complaints:		
5.5. Printer - 19.5 Printer - 19.5 Printer - 19.50 Printer - 19.50	fected by this condition?			
Location of Symptoms and Radia	MAJOR COMPLAINT			
G G G	Quality:	Previous Treatment:		
		□ None		
CID IN OR	☐ Stabbing			
A R	Burning	☐ Chiropractor		
1/1-1/1 11 1754		Medical Doctor Physical Therapy		
	Dull	☐ Physical Therapy☐ ER/Urgent Care		
	☐ Stiff & Sore	Orthopedic		
	☐ Other:	Other:		
R	Does it radiate?			
	☐ No ☐ Yes (Please indicate on drawing	Previous Diagnostic Testing: None		
D D .	Improves with:			
P Pain T Tender N Numb H Hypoesthes		☐ X-rays		
S Spasm	☐ Heat	□ MRI		
ade Intensity/Severity:	☐ Movement	☐ CT		
None (0/10)	☐ Stretching	Other:		
Mild (1-2/10)	OTC Medications:	*Women: Are you pregnant?		
Mild-Moderate (2-4/10)	Other:			
Moderate (4-6/10)	Worsens with:			
Moderate-Severe (6-8/10)	□ Sitting	Present Illness Comments:		
Severe (8-10/10)	☐ Standing/Walking			
quency:	☐ Lying Down/Sleeping			
Off & On	☐ Overuse/Lifting			
Constant	Other:			
escription Medications & Supplen	ments: None Allergies to Me	edications: No known drug allergies		
Yes (List - Name, dosage, frequency)	☐ Yes (List - Nam	ne and reaction)		
ve answered these questions to the best of				
ent or Guardian Signature	of my knowledge and certify them to be true and corr	ect.		
		Date		

Account No:

PAST, FAMILY, AND SOCIAL HISTORY

Illnesses: Asthma				Please select all that apply and use comments to elaborate.) Hospitalizations: (Non-surgical with Date)						Medical History Comments:
☐ Autoimmune Disorder	(Type)			-					_	2000
☐ Blood Clots			7000							
Cancer (Type)		~	_	Surge	ries: (1)	fyes, pi	ovide ty	pe & si	urgery date)	
☐ CVA/TIA (stroke)☐ Diabetes										300
				□ O.	rthoped	lic				
☐ Migraine Headaches☐ Osteoporosis					Sho	ulder	-R/I	,		
Other:				Elb	OW/FOI	earm	-K/I			
Other:			-		Wrist/	Hand	- R / L	,		
<u> </u>			-			HID	-R/I	,		
			_		A rol.1 - 4	nee -	-K/L			
njuries:				□ Sp	Ankle/ oinal Su	Foot -	-R/L			
☐ Back Injury				_ 5 p	Meck	ugery				
☐ Broken Bones				0 8	Back:					
☐ Head Injury					_		- 37 77 77 77 77 77 77 77 77 77 77 -			
□ Neck Injury □ Falls				□ Ot	her:					
Other:			78							
	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3		story Comments:
Cond			Sik	Sib	Sib	δ	ర	ರ		
Age at death (if Deceased)	F	M								
rige at death (if Deceased)		market and				and the same			-	
A nous ware					- 1					
Aneurysms			1. 100 5.100	Maria de la Companya						
CVA (Stroke)										
CVA (Stroke) Cancer										
CVA (Stroke) Cancer Diabetes										
CVA (Stroke) Cancer Diabetes Heart Disease										
CVA (Stroke) Cancer Diabetes Heart Disease Hypertension										
CVA (Stroke) Cancer Diabetes Heart Disease Hypertension Other Family History						W. 11				
CVA (Stroke) Cancer Diabetes Heart Disease Hypertension	RY							and the last		
CVA (Stroke) Cancer Diabetes Heart Disease Hypertension Other Family History	RY									
CVA (Stroke) Cancer Diabetes Heart Disease Hypertension Other Family History MAL AND OCCUPATIONAL HISTOR Marital Status: Single	RY Marrio	ed □ I					Smo	king/	Tobacco Use:	If current smoker, amount =
CVA (Stroke) Cancer Diabetes Heart Disease Hypertension Other Family History MALAND OCCUPATIONAL HISTOR Iarital Status: Single hildren: None 1 2	RY Marrio	ed □ I					Smo	king/	Tobacco Use: / Day □ Son	If current smoker, amount = $_$ ne Days \Box Former \Box Never
CVA (Stroke) Cancer Diabetes Heart Disease Hypertension Other Family History MALAND OCCUPATIONAL HISTOR Iarital Status: Single hildren: None 1 2 ther:	Marrie	ed □ I	Divorce	ed □ C	Other		Smo	king/ Every	Day 🗆 Son	If current smoker, amount = \Box ne Days \Box Former \Box Never
CVA (Stroke) Cancer Diabetes Heart Disease Hypertension Other Family History MAL AND OCCUPATIONAL HISTOR Marital Status: Single hildren: None 1 2 ther:	Marrie 3 c	ed 🗆 I 4 🗆 Part St	Divorce	ed □ C	Other Studen	t	Smo	Every	Day 🗆 Son	ne Days 🗆 Former 🗀 Never
CVA (Stroke) Cancer Diabetes Heart Disease Hypertension Other Family History MALAND OCCUPATIONAL HISTOR Ilarital Status: Single hildren: None 1 2 ther: Ludent Status: Full Studighest level of Education:	Marrie 3 cent High	ed 🗆 I 4 Part St gh Sch	Divorce udent [ed 🗆 C Non-	Other Studen Grad.	t	Smo	Every hol Us Every eine U	Day □ Son se: Day □ Wed	ne Days □ Former □ Never
CVA (Stroke) Cancer Diabetes Heart Disease Hypertension Other Family History MAL AND OCCUPATIONAL HISTOR Iarital Status: Single hildren: None 1 2 ther: Ludent Status: Full Studighest level of Education: Post Grad. Other:	Marrie 3 C	ed 🗆 I 4 Part St gh Sch	Divorce udent [ool [] (ed 🗆 C Non-College	Other Studen Grad.	t	Smo	Every hol Us Every eine U	Day □ Son se: Day □ Wed	ne Days □ Former □ Never
CVA (Stroke) Cancer Diabetes Heart Disease Hypertension Other Family History MALAND OCCUPATIONAL HISTOR Marital Status: Single Children: None 1 2 Ther: Cudent Status: Full Studighest level of Education: Post Grad. Other: Canployed: No 2 Yes (Comparison of Comparison of Comparis	Marrie 3 Cecupati	ed	Divorce udent [ool [] (ed 🗆 C	Other Studen	t	Smo	Every hol Us Every eine U	Day □ Son se: Day □ Wed	ne Days Former Never
CVA (Stroke) Cancer Diabetes Heart Disease Hypertension Other Family History MALAND OCCUPATIONAL HISTOR Marital Status: Single hildren: None 1 2 ther: Mudent Status: Full Studighest level of Education: Post Grad. Other: mployed: No Yes (Comminant Hand: Right	Marrio 1 3 1 ent 1 His	ed	Divorce udent [ool Ambie	ed 🗆 College	Studen Grad.	t	Smo	Every hol Use Every eine U Coffe cise fr	Day Son	ne Days
CVA (Stroke) Cancer Diabetes Heart Disease Hypertension Other Family History MAL AND OCCUPATIONAL HISTOR Marital Status: Single Children: None 1 2 Cher: Code Status: Full Studighest level of Education: Post Grad. Other: Company Of Status: Right Commant Hand: Right Cial History Comments:	Marrio 3 Gent Gillian High	ed I 4 Part St Sch	Divorce udent [ool 0	ed 🗆 College	Studen e Grad.	t	Smo	Every hol Us Every eine U Coffe cise fr	Day Son	ne Days
CVA (Stroke) Cancer Diabetes Heart Disease Hypertension Other Family History MALAND OCCUPATIONAL HISTOR Marital Status: Single hildren: None 1 2 ther: Mudent Status: Full Studighest level of Education: Post Grad. Other: mployed: No Yes (Comminant Hand: Right	Marrie 3 cent : His	Part St gh Sch fon) eft	Divorce udent [ool] (Ambie	Non-College	Studen e Grad.	t fy then	Smo	Every hol Use Every eine U Coffe cise fr Daily	Day Son	ne Days

REVIEW OF SYSTEMS

REVIEW OF SYSTEMS

Account No:

Many of the following conditions respond to chiropractic treatment.

Are you <u>currently</u> experiencing any of these symptoms? (Please select all that apply and use comments to elaborate.)

Constitutional: (General) Fever	Respiratory:	Review of Systems Comments:
☐ Fatigue	☐ Difficulty Breathing	# #F
Other:	Cough	
□ None in this Category	Other: None in this Category	
Musculoskeletal:		
☐ Joint Pain/Stiffness/Swelling	Eyes & Vision:	
☐ Muscle Pain/Stiffness/Spasms	☐ Eye Pain	
Broken Bones	☐ Blurred or Double Vision	
Other:	☐ Sensitivity to Light	
☐ None in this Category	☐ Other: ☐ None in this Category	_
Neurological:		
☐ Dizziness or Lightheaded	Head, Ears, Nose, & Mouth/Throat:	
☐ Convulsions or Seizures	Frequent or Recurrent Headaches	
☐ Tremors	☐ Ear - Ache/Ringing/Drainage	
☐ Other:	☐ Hearing Loss	
☐ None in this Category	Sensitivity to Loud NoisesSinus Problems	
	Sinus Problems Sore Throat	
Psychiatric: (Mind/Stress) Nervousness/Anxiety	Other:	
☐ Depression	□ None in this Category	
☐ Sleep Problems	Property Control of the Control of t	
Memory Loss on Court	Endocrine:	
Memory Loss or ConfusionOther:	☐ Infertility	
None in this Category	☐ Recent Weight Change	
	☐ Eating Disorder	
Genitourinary:	Other:	
☐ Frequent or Painful Urination	□ None in this Category	
☐ Blood in Urine	Hematologic & Lymphatic:	
☐ Incontinence or Bed Wetting	 Excessive Thirst or Urination 	
☐ Painful or Irregular Periods	☐ Cold Extremities	
Other:	☐ Swollen Glands	
□ None in this Category	☐ Other:	
Gastrointestinal:	□ None in this Category	
☐ Loss of Appetite	Integumentary: (Skin, Nails, & Breasts)	
☐ Blood in Stool or Black Stool	Rash or Itching	
□ Nausea or Vomiting	Change in Skin, Hair, or Nails	
☐ Abdominal Pain	□ Non-healing Sores or Lesions	
☐ Frequent Diarrhea	Change of Appearance of a Mole	
☐ Constipation	Breast Pain, Lump, or Discharge	
Other:	Other:	
None in this Category	None in this Category	
ardiovascular & Heart:	Allergic/Immunologic:	
Chest Pains/Tightness	☐ Food Allergies	
Rapid or Heartbeat Changes	☐ Environmental Allergies	
Swelling of Hands, Ankles, or Feet	Other:	
Other: None in this Category	□ None in this Category	
None in this Category		
have answered these questions to the best of m	ry knowledge and certify them to be true and correct.	
ariont of Quartian Signature		Date
III LUSI)		

Epic Lifestyle Chiropractic

Patient Name:	D.O.B.:	Date:
	Consent for Chiropractic Se	ervices
By reading below I have been m	<u>1ade aware:</u>	
structures (legs, arms etc.), off 2. As an addition to the Capplied by the chiropractor or use of light, sound, vibration, 3. That on occasion some aggravation of presenting symrare separation/fracture; and exprocess of a Chiropractic Adju	ten resulting in an audible pop or of thiropractic Adjustment "Support by staff under the chiropractor's delectricity, traction, motion, bracing temporary soreness and/or stiffner aptoms or initiation of new symptoms are nerve or vascular in the chiropractic stremely rare, nerve or vascular in the chiropractic stremely rare.	vertebra(e) of the spine and/or associated click sound; ive Therapies and/or Procedures" may be direction or supervision incorporating the ng, nutritional advice, heat, or cold; ess may occur; less frequently oms; rarely bruising, swelling, even more njury may occur in conjunction with the
Additionally:	as made no guarantee of a positiv	e outcome from freatment.
	mple opportunity for questions and	d answers.
Therefore by signing below:		
I <u>consent</u> to the performance of t staff under the direction and supe	the diagnostic and therapeutic procervision of the office chiropractor(cedures performed by the doctor and or s) involved in my case;
I <u>consent</u> to the performance of of deemed reasonable and necessary office chiropractor(s) involved in	by the doctor and or staff under t	rocedures in the future that may be the direction and supervision of the
Patient Signature:		
Witness Signature		

Epic Lifestyle Chiropractic

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

D.O.B.:____

Date:

Patient Name: _

	<u>AUTHORIZATION:</u> By signing below you authorized this office/provider to complete a consultation and examination on the above.
	<u>AUTHORIZATION FOR X-RAY WITH RELEASE:</u> By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.
	ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.
: ·	CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."
	ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personal health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.
	ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.
	ACKNOWLEDGEMENT: By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.
	Signature of Patient: