Welcome To Santa Fe Chiropractic Center

If you have insurance please notify the front desk and present the insurance card to the receptionist...

Today's Date_____ Email: _____

Name _____ I prefer to be called:_____ Male Female (circle one)

Last First MI

Home Address_____

Mailing Address _____

Home phone _____Work phone _____ Driver's License #_____

Birth date ____/____/____ Age_____ Social Security # _____ Single Married Divorced Widowed, (circle one)

How many children do you have? _____How did you find out about this office?_____

Employer: _____How long there? _____Occupation_____

Employer's Address _____ Employer's phone # _____

Person Responsible for Account

Name_____ Relation: _____ Telephone _____

Spouse Information

His / Her Name: _____ Birth date: ____/____/_____ SS#_____

Employer:_____ Work Phone _____

Name and address of neighbor or relative not living with you_____

_____Telephone _____

Medical History

IS IT POSSIBLE YOUR CONDITION IS DUE TO AN INJURY OR ACCIDENT AT WORK? YES NO circle one

Is your condition due to an auto accident? Yes No (circle one) Is your condition caused by any type of accident? Yes No (circle one)

Do you have a personal physician? yes no (circle one)

Physician's Name_____

Address: _____

Phone # _____ Date of last visit _____

Your current physical health is:	Good Fair Poor (Please circle)
Are you currently under the care of a physician?	Yes No
Please explain_____	
Do you smoke or use tobacco in any other form	Yes No
Are you right/left handed?	R L
Have you ever been to a Chiropractor?	Yes No
If yes, for what_____	
Name of Chiropractor _____	
Have you ever been involved in a bicycle, motorcycle, bus, train, or vehicular accident?	Yes No
Were you ever knocked unconscious?	Yes No
Have you ever or do you use a walker or cane?	Yes No
Have you ever broken any bones?	Yes No
Have you had any impacts, falls or jolts that you feel could have injured your spine?	Yes No
Do you read for prolonged periods of time?	Yes No
Do you sit in front of a computer for prolonged periods of time?	Yes No

During the day, I: sit, stand, walk, desk work, phone work, drive, mechanical work, heavy lifting, (please circle appropriate ones).

Symptom/Pain Information

Name_____ Today's Date _____

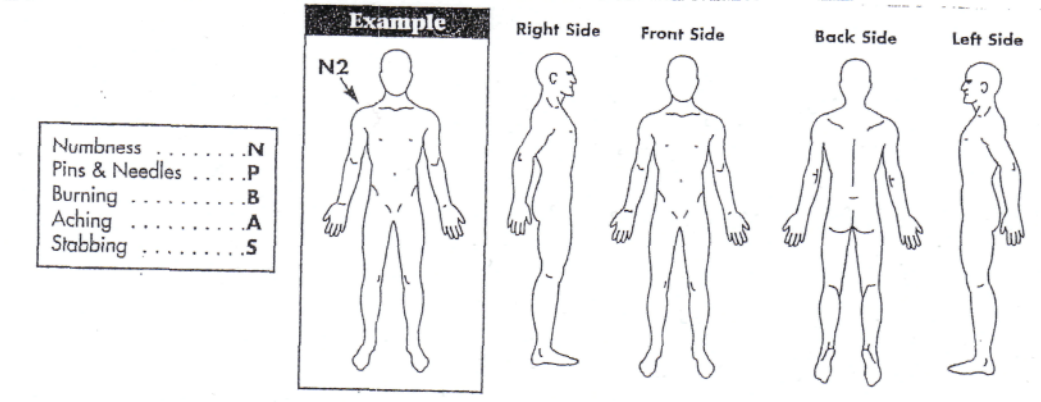
Please describe the health problem for which you came to this office: _____

Please describe the character and location of your symptom (s) Some words often used include burning, aching, tired, numb, sharp, dull, stabbing, shooting, radiating, etc _____

_____

What type of physical activity or posture does your job involve? (prolonged sitting, bending, etc.)_____

Please mark area (s) of injury or discomfort as shown below in the example. Include degree of pain using a scale of 1 (discomfort) to 10 (extreme pain)



How long have you had this episode of symptoms? _____

How many times have you had a problem similar to or the same as this in the past? _____

When was the first time you ever felt something similar to or the same as your current problem? _____

Did the symptoms begin ☐ Gradually ☐ Suddenly Since your symptoms began, have they? improved worsened same (circle one)

Are your symptoms constant? yes no If yes explain: _____

Are there any times or positions when you do not experience your pain/discomfort (e.g. after exercising, while sleeping)? yes no

If yes, explain: _____

What caused your symptom (s) to occur? _____

What aggravates your current symptoms? _____

Have you done anything to try and help relieve your complaint such as rest, heat, cold, aspirin?_____

Is your sleep disturbed by these symptoms? yes no Do you sleep on a Mattress Waterbed Futon other_____

What is your normal sleeping position? back stomach side other _____

How old is your current mattress?_____

Are you restricted/limited in any work, home, or recreational activities because of your discomfort? yes no

If yes, explain _____

Are you doing any corrective exercises for your present symptoms? yes no

If yes, briefly describe the exercises/stretches you are doing and who recommended them: _____

What kind of exercises do you participate in?_____

_____

Have you seen another health care professional for this problem? yes no If so, who? (Please list all

Were X Ray's taken? yes no What type of treatment was done?_____

On a scale of 1 (no improvement) to 10 (full improvement), how much did the treatment help?_____

Have you seen a chiropractor, physical therapist, or osteopath for any other problem? yes no (circle one)

Are you aware of any blood relatives with similar discomforts/problems? yes no (circle one)

If yes, please explain: _____

Medical History Continued

Do you take vitamins or minerals? Yes No

Do you think you may need to take vitamins and or minerals? Yes No

Are you wearing: Heel lifts, Sole lifts, Inner soles, arch supports? _____ Yes No

Are you under a lot of stress on a daily basis? Yes No

How long has it been since you really felt good_____

For Women:

Are you taking birth control pills? Yes No

Are you pregnant? Unsure Yes No (circle one) Week#_____

Are you nursing? Yes No

Age periods stopped and why? _____

Medications are you currently taking, and for what purpose are you taking them?_____

_____

_____**(if you need more space please use the back of the first page)**

Do you have or had any of the following? Please circle appropriate ones.

Abnormal Bleeding	Congenital Heart Defect	Headaches	Migraine	Shingles
Alcohol Abuse	Depression	Heart Disease	Mitral Valve Prolapse	Sickle Cell
Allergies	Diabetes	Hemophilia	Obesity	Sinus Problems
Anemia	Difficulty Breathing	Hepatitis	Pacemaker	Stroke
Arthritis	Drug Abuse	herpes	Persistent Cough	Thyroid Problems
Artificial Bones/Joints	Emphysema	High Blood Pressure	Psychiatric Problems	Tonsillitis
Artificial Valves	Epilepsy	HIV + / Aids	Radiation Treatment	Tuberculosis
Asthma	Fainting Spells	Hospitalizations	Rheumatic Fever	Ulcers
Blood Transfusion	Fatigue	Kidney Problems	Rheumatism	Venereal Disease
Cancer	Fever Blisters	Leukemia	Scarlet Fever	
Chemotherapy	Glaucoma	Liver Disease/Problems	Sciatica	
Chicken Pox	Gout	Low Blood Pressure	Scoliosis	
Colitis	Hay Fever	Lupus	Seizures	

Please list any other serious medical condition (s) that you have or have experienced_____

_____ If you need more space use the back of the first page.

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections form the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me to be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize Santa Fe Chiropractic Center to furnish all information required by insurance company concerning my injury or illness. I also authorize the Santa Fe Chiropractic Center Inc. to contact me by phone or in writing to remind me of an appointment. This authorization also give permission to mail me any notices of payments due or bulletins that may be beneficial to my health.

_____ My method of payment will be Cash Check Credit Card (circle one)

Signature Date

Santa Fe Chiropractic Center, Inc.

J.B. BARFOOT, D.C.
RALLEEN F. GLASIN, D.C.

P.O. BOX 987
SANTA FE, TEXAS 77510-0987

12122 HWY. 6
A/C (409) 925-1803

INSURANCE ASSIGNMENT OF BENEFITS

I hereby authorize payment of benefits directly to Santa Fe Chiropractic Center, Inc. for the medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for Services rendered. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of charges over and above this insurance payment. I hereby authorize Santa Fe Chiropractic Center, Inc. to release the minimum necessary information to my insurance carrier(s) to process my claims.

Initials: _____

RELEASE OF INFORMATION

I, _____ authorize Santa Fe Chiropractic Center, Inc. to release all information to the following healthcare provider, employer, or attorney.

Name:_____
Address:_____
City/State/Zip:_____
Telephone#:_____

HIPAA RELEASE

I understand that a copy of the Santa Fe Chiropractic Center, Inc. Notice of Privacy Practices patient privacy rights disclosure is posted in the front office and also available to me, at my request in accordance with the Health Insurance Portability & Accountability Act.

I would like a copy of my patient privacy rights

_____Yes _____No If Yes Initial receipt of copy_____

HIPPA CONTACT RECORD

Please contact me as follows (check all that applies)

Home/Cell/Work telephone#_____

_____Leave message with date & Time
_____Leave message call-back number only
_____Leave message with detail information
_____Do not leave message
_____Notify family member

_____Written communication
_____mail to my home address
_____Mail to my work/Office
_____Fax me @_____

Home Address: _____
_____
_____

Work Address: _____
_____
_____

Signature:_____ Date_____