CONFIDENTIAL PATIENT DATA

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Date: ______________________

Have you ever been treated by a Chiropractor before? YES NO SS# ________________

PATIENT INFORMATION:

Name: ____ Birthdate: __________________

Nickname: __________________ Male Female Age: _____________________

Mailing Address: ____

____

CITY STATE ZIP

Phone Home#____________________________ Cell#________________________________

Status: MINOR SINGLE MARRIED DIVORCED SEPARATED WIDOWED

Spouses Name: __________________________________ Spouse's Number: (____) __________

Whom can we thank for referring you? INTERNET LOCATION OF OFFICE PHONE BOOK

Friend or Family: _____________ Other: ___________

Employer: _______________________________________ Occupation: _____________________

Employers Address: ____ Phone:___________

CITY STATE ZIP

IN CASE OF EMERGENCY:

Whom should we contact: _______________________________

Relation: ________________________ Contact Number: (_____) ______________

INSURANCE INFORMATION:

Insurance Company: ______________________ Secondary Insurance: _____________________

ID #: __________________________________ Group #: ___________________________________

Card Holders Name: ________________________________ Card Holders DOB: _______________

Patients Relation to Card Holder: ______________________

REASON FOR VISIT:

NEW INJURY OLD INJURY CHRONIC PAIN

How did your injury occur: WORK SPORTS/PLAY AUTO ACCIDENT ROUTINE

When did your condition begin? ________________________ Where? _______________________

List any past serious injuries with dates: ____

____

Is your condition getting worse? YES NO CONSTANT COMES AND GOES

Is your condition interfering with: WORK SLEEP DAILY ROUTINE

If any, how: ____

Has this happened in the past? YES NO EXPLAIN: ____

HEALTH HISTORY:

Are you taking any of the following medications? Nerve pills Pain killers Muscle relaxers Insulin Blood Thinners Tranquilizers

Other Current Medications:

1. Drug Name: ___________________ Strength (ex. 10mg) ______ Dose (ex. 1 tab) _______
   Frequency: (ex. Once daily) ____________________ Date started: ____________________
2. Drug Name: ___________________ Strength (ex. 10mg) ______ Dose (ex. 1 tab) _______
   Frequency: (ex. Once daily)___________________ Date started: ___________________
3. Drug Name: ___________________ Strength (ex. 10mg) ______ Dose (ex. 1 tab) ______
   Frequency: (ex. Once daily) ____________________ Date started: ____________________

Drug Allergies:

1. Drug Name: _______________________ Reaction: (ex. Hives) _______________________
2. Drug Name: _______________________ Reaction: (ex. Hives) _______________________
3. Drug Name: _______________________ Reaction: (ex. Hives) _______________________

Do you take Supplements or Vitamins? YES NO Do you exercise? YES NO ____hrs/week

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	**Y N** Chemotherapy	**Y N** Migraines
Y N Artificial Valves	**Y N** Heart Murmur	**Y N** Emphysema / Asthma
Y N Shingles	**Y N** Venereal Disease	**Y N** Artificial Bones / Joints
Y N High / Low Blood Pressure	**Y N** Frequent Neck Pain	**Y N** Metal Implants
Y N Ulcers / Colitis	**Y N** Rheumatic Fever	**Y N** Mitral Valve Prolapse
Y N Difficulty Breathing	**Y N** Sinus Problems	**Y N** HIV+ / AIDS / ARC
Y N Heart Surg. / Pacemaker	**Y N** Lower Back Problems	**Y N** Anemia / Diabetes
Y N Alcohol / Drug Abuse	**Y N** Congenital Heart Defect	**Y N** Kidney Problems
Y N Cancer	**Y N** Hepatitis A B or C	**Y N** Tuberculosis
Y N Psychiatric Problems	**Y N** Glaucoma	**Y N** Arthritis
Y N Fainting / Seizures	**Y N** Severe / Frequent Headaches	**Y N** Ever Been Shot

Surgical History:

1.________________________ Date: __________ 2.________________________ Date:__________

3. ________________________ Date: _________ 4. ________________________ Date: __________

Accident History: Job Auto Other ___________________ Date ______________

Job Auto Other ___________________ Date ______________

Do you smoke? NO YES How much? ________________________ How long? ____________

Do you use: Shoe Lifts In-Soles Arch Supports

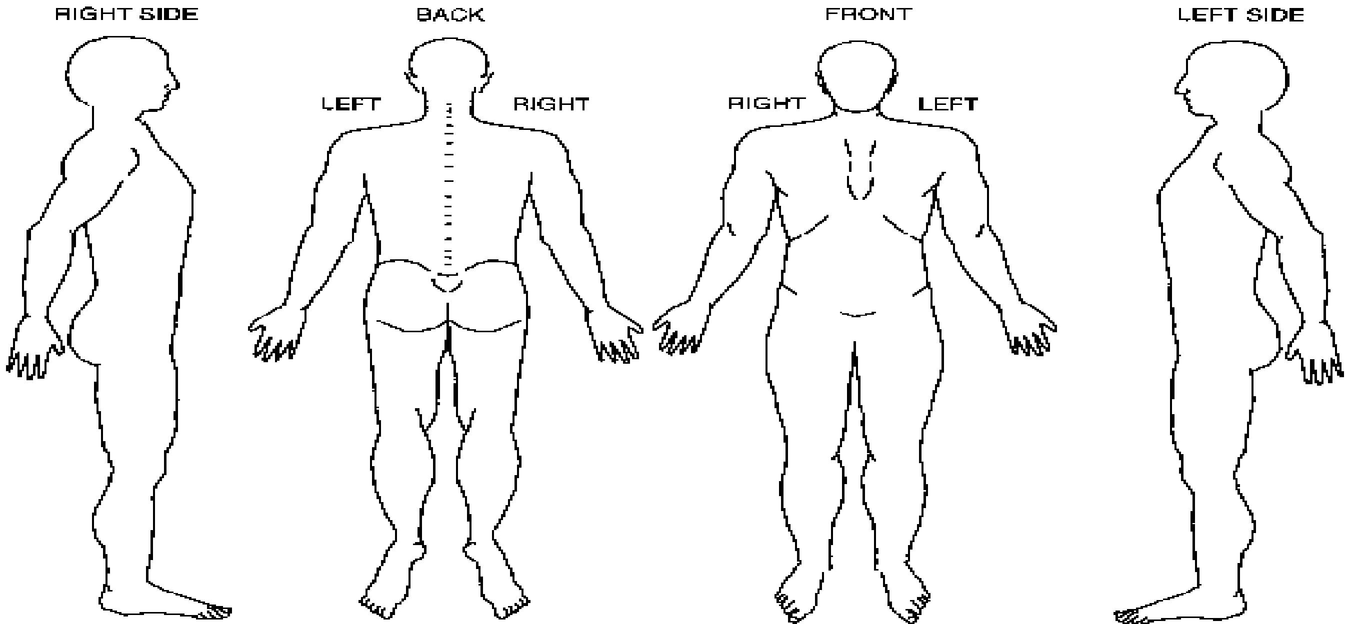
For Women:

Are you on Birth Control? YES NO Are you using Hormonal Replacements? YES NO

Are you Pregnant? YES NO How many weeks? ______ Are you nursing? YES NO

How many children do you have? __________ Date of last menstrual cycle: ____________

USING THE BODY CHARTS BELOW, PLEASE CIRCLE ALL AFFECTED AREAS



Please describe present major complains: Rate each pain 1-10 (10 being the worst)

1. ____ ________
2. ____ ________
3. ____ ________
4. ____ ________
5. ____ ________

When and How?____

____

If in an Auto Accident, were you hit by the airbag? YES NO

Symptoms are worse in the: MORNING AFTERNOON NIGHT COMES&GOES CONSTANT

Please check mark the activities that you are having problems performing or are experiencing pain while doing. This should agree with your circles areas of pain.

Computer Use (extended)	Computer Use (short time)	Caring for Infirm Person	Cervical Range of Motion
Desk Work	Drawing	Driving	Exercise
Lying Down	Playing Piano	Reading	Running
Sitting	Standing	Staying Asleep	Falling Asleep
Walking	Yard Work	Bathing	Bending
Concentrating	Cycling	Child Care	Climbing Stairs
Using the Phone	Dressing	Golf	Hair Care
Kneeling	Lifting	Pet Care	Needlework
Looking over shoulder	Sexual Activities	Shaving	Swimming

Notice of Privacy Practices- Acknowledgement and Consent

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your protected health information will be used by Gilstrap Clinics or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the **Notice of Privacy Practices** for a more complete description of how your protected health information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the notice at the front desk.

Requesting a restriction on the use or disclosure of your information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

____ ____________

Patient or Legally Authorized Individual Signature Date

____

Print Patients Full Name

Authorization Release Form:

In consideration of your undertaking to care for me, I agree to the following:

1. You, Gilstrap Clinics, are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
3. Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the Doctor. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
4. I authorize the staff of Gilstrap Clinics to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
5. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform Gilstrap Clinics of any changes to the information I have provided.
6. I authorize the direct payment to you of any sum I now or hereafter owe Gilstrap Clinics by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
7. In the even any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name as you see fir and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you, Gilstrap Clinics, do not collect from insurance company proceeds, whether it be all or part of what is due, I personally owe you.
8. In addition to the above, I hereby waive the statute of limitations on collection and/ or recovery in Oklahoma.
9. I further agree that this authorization and assignment is irrevocable until all monies owed are paid in full.

Signature ____Date____________

Parental Consent:

This authorizes Gilstrap Clinics to treat my minor child, ____ , without me,

Minor

____, present on their visits for their treatments.

Parent/Guardian