

# HARER & MORTENSEN CHIROPRACTIC

# Patient History Form

Name Mr / Mrs / Ms \_\_\_\_\_ Nickname \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Email Address \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Ext# \_\_\_\_\_ Cell # \_\_\_\_\_

Birth date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex M / F Status M S W D Referred to our office by \_\_\_\_\_

Age \_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Employer \_\_\_\_\_ SS # \_\_\_\_\_

Parent's Name (If Pt is a minor) \_\_\_\_\_ Health Plan \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Date problem began \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Is Injury Work Related? Yes / No Auto Accident? Yes / No

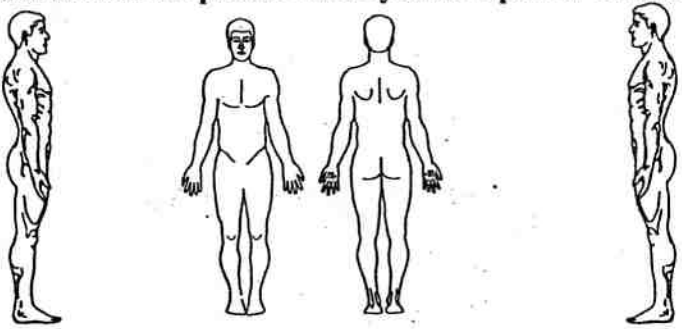
Describe how your problem began \_\_\_\_\_

What do you hope to achieve with care? \_\_\_\_\_

Rate your pain 1(no pain) to 10 (severe): \_\_\_\_\_ Your pain is: Constant Frequent Occasional Intermittent

Prior Treatment (medications, therapy, chiropractic, MRI, X-rays) \_\_\_\_\_

Mark an X on the picture where you have pain or other svmtoms



Have you ever had or do you now have:

- Y / N Diabetes
- Y / N Cancer
- Y / N Stroke
- Y / N Sciatica
- Y / N Dizziness
- Y / N High Blood Pressure
- Women Only : Y / N Lumps in Breast
- Y / N Colon Trouble
- Y / N Heart Disorders
- Y / N Arthritis
- Y / N Kidney Disorder
- Y / N Headaches
- Y / N Menstrual Problems

Date of last menstrual cycle \_\_\_\_\_

While Harer Chiropractic may assist me in collecting reimbursements from my insurance/benefit provider, I understand that I remain solely responsible for payment of all services rendered to me. I understand that should my account become delinquent, I may be assessed an interest charge of 10% of the delinquent amount and upon the conclusion of my care, all fees for professional services rendered me will be due and payable.

I hereby instruct and direct my insurance company to pay by check made out and mailed to:

Karl R. Harer Chiropractic Inc. 4517 MARKET Ste 1 VENTURA, CA 93003

This is for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered me.

Signature : \_\_\_\_\_

### Authorization to Release Records and Information

To: \_\_\_\_\_ I, \_\_\_\_\_ (patient's name) DOB \_\_\_\_\_

Request Records/ Information be released to Harer & Mortensen Chiropractic 4517 Market #1 Ventura, Ca 93003

Signature: \_\_\_\_\_