PATIENT CONFIDENTIALITY PERSONAL DATA

Date_____
Patient:_____**Date of Birth:**_____
Home Address:_____**City:**_____ **State:**___ **Zip:**_____
Preferred Contact Phone:_____**Email:**_____
Employer:_____**Type Of Work Done:**_____
Name of Spouse:_____**No. of Children:**_____
Who can we thank for getting you to the right place?_____
Purpose of this appointment and list your complaints:_____
Date of illness/issue/accident: _____**Location:**_____
If accident how did it occur? Auto/Job/Other,_____
Please describe the circumstances and what makes the condition(s) better:_____

_____

_____

Please describe the circumstances and what makes the condition(s) worse:_____

_____

_____

Other doctor(s) seen for this condition:_____

_____

Has this issue happened before? Yes/No If so, when?:_____

_____

If yes, why do you think your body failed to heal this time?_____

_____

What do you think might lie at the root of your issue?_____

_____

How would you rate your happiness level on a scale of 1 to 10?_____
How would you rate your daily stress level on a scale of 1 to 10?_____
Do you think that your issue may be tied to physical/chemical/emotional stress or all of the above? _____

_____

What would be the biggest life change for you if your physical/chemical/emotional stress was significantly reduced or neutralized_____

_____

Have you been treated by a Doctor for any other health condition in the last year? Yes/No If yes, please describe:_____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in any case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient's Signature:_____**Parent's or Guardian's Signature:**_____