



Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS#: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Primary Care Physician Information

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

### CONFIDENTIAL PATIENT INFORMATION

This information is confidential. If we do not sincerely believe your problem will resopns favorably, we will not accept your case. We will refer you to disciplines we believe will help you. In order for us to understand your health problems, please complete this form neatly, accurately and completely. Thank you!

Date: \_\_\_\_\_

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Marital Status: S M W D How Many Children: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Name of Wife/Husband: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Other Nearest Relative: \_\_\_\_\_ Phone: \_\_\_\_\_

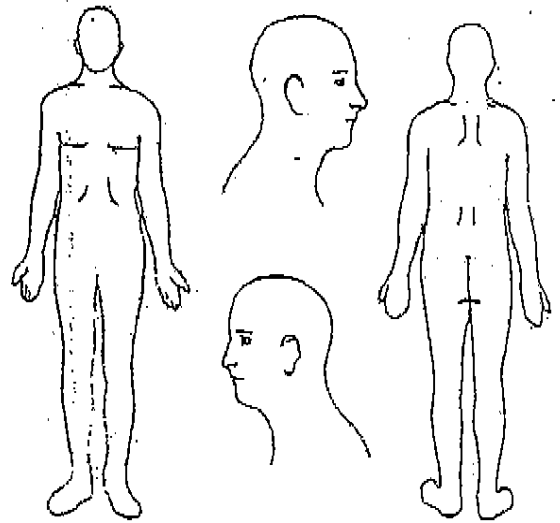
List present complaints, injuries and duration:

Please mark your area of pain on the figures below:

1. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



Remarks and details of any accident:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List other doctors consulted for present complaints and injuries:

Name: \_\_\_\_\_ When Consulted: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Treatment: \_\_\_\_\_

How long did you see the Doctor? \_\_\_\_\_ How frequently: \_\_\_\_\_

Results: \_\_\_\_\_

Name: \_\_\_\_\_ When Consulted: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Treatment: \_\_\_\_\_

How long did you see the Doctor? \_\_\_\_\_ How frequently: \_\_\_\_\_

Results: \_\_\_\_\_

Present Family Doctor: \_\_\_\_\_ Date of last physical examination: \_\_\_\_\_

What surgeries have you had?

Type/When/Doctor/Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List former serious accidents and falls: (circle one ~ auto, work, home, leisure, sports, other)

What/When/Symptoms/Treatment/Results: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List broken bones:

What/When/Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Medications and/or diet supplements you take:

What/Frequency/Doctors/Side Effects/Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Environment:

Work ~ Please circle appropriate answer

Seated/Standing ~ Work Bench/Desk/Counter/Other: \_\_\_\_\_

Job Involves ~ Lifting/Bending/Stooping/Twisting/Carrying/Walking/Standing/Other: \_\_\_\_\_

Chair ~ Executive/Steno/Bench/Stool/Folding/Other: \_\_\_\_\_

Shoes ~ High heels/Boots/Other: \_\_\_\_\_

Leisure:

Sedentary activities? Standing/Seated/Lying? TV/Reading/Card Games/Sewing/Other (Please describe)  
\_\_\_\_\_

Strenuous activities? Exercise ~ Type/Frequency/Length of time? \_\_\_\_\_  
\_\_\_\_\_

Sports ~ Type/Frequency/Length of time? \_\_\_\_\_  
\_\_\_\_\_

If you have discontinued sports or strenuous activities, why the change? \_\_\_\_\_

Exert Yourself ~ Frequently/Occasionally/Rarely/Never? Describe how: \_\_\_\_\_  
\_\_\_\_\_

**Circle Current Conditions ~ Check Former Conditions****Nervous System**

Hot/Cold Spots	Nervousness	Insomnia	Numbness/Tingling
Personality Change	Depression	Fainting	Irritability
Forgetfulness	Paralysis	Tremors	Hiccups
Dizziness	Anxiety	Confusion	Convulsions Tension

**Eye, Ear, Nose and Throat**

Visual Disturbances	Hearing Loss	Canker Sores	Zig Zag Flashes
Nose Pain	Difficulty Speaking	Eye Strain	Nose Bleeding
Sinus Trouble	Eye Inflammation	Nose Discharge	Hay Fever/allergies
Sore Throat	Chronic Earache	Hoarseness	Ear Noises
Sore Mouth/Gums	Head Colds	Difficulty Breathing through Nose	
Light Sensitivity	Ear Discharge	Dental Problems	

**Respiratory**

Difficulty Breathing	Asthma	Tuberculosis	Chronic Cough
Allergies	Chest Colds	Coughing Phlegm/Blood	

**Cardio-Vascular**

Heart Attack	Slow Beating Heart	Poor Circulation	High Blood Pressure
Pain over Heart	Stroke	Low Blood Pressure	Hardening of Arteries
Varicose Veins	Rapid Beating Heart	Swelling of Ankles	

**Skin**

Skin Disorder	Itching	Boils	Acne
Bruise Easily	Hives or Allergies	Shingles	Dryness

**General**

Fever	Sweats	Cancer	Thyroid Disorder
Rheumatic Fever	Loss of Weight	Chills	Chronic Fatigue
Weight Trouble	Diabetes		

**Gastro-Intestinal**

Chronic Nausea	Belching Gas	Diverticulosis	Vomiting
Gastritis/Heartburn	Hemorrhoids	Vomiting Blood	Pain over Stomach
Liver Trouble	Food Allergy	Jaundice	Poor Appetite
Gall Bladder Trouble	Black Stool	Excessive Hunger	Constipation
Excessive Thirst	Diarrhea	Bloody Stool	Ulcers/Stomach Disorder
Colitis	Difficulty Chewing/Swallowing		

**Genito-Urinary**

Urine Disorder~Frequent/Excessive/Scanty/Painful/Discolored/Blood/Pus	Impotency
Bladder Trouble	Kidney Infections/Stones Bed-Wetting Prostatitis

**Female**

Periods ~ Painful/Excessive	Hot Flashes	Menopause Symptoms
Irregular/Cramps	Breast Lumps/Congested	Pregnant ~ Yes or No

**Musculo-Skeletal**

Recurring Headaches	Eye or Sinus Pain	Facial Spasms	Facial/Jaw Pain
Restricted Movement ~ Head/Neck	Neck Pain	Neck Spasms	Poor Posture
Upper Back Pain	Swollen Arm/Hand	Vision Problems	Pain/Stiff Joints
Sore, Aching "Shawl" Muscles	Shoulder/Arm/Hand	Arthritis	Bursitis
Pain Beneath/Under Shoulder Blade	Mid Back Pain	Chest Pain	Rib Cage Pain
Pain Beneath/Below Breast Bone	Hiatal Hernia	Scoliosis	Rheumatism
Restricted Movement ~ Torso	Low Back Pain	Neuritis	Neuralgia
Lumbago	Painful Tailbone	Buttock Pain	Hip Pain
Sciatica	Leg Cramps	Leg Pain ~ Lower/Upper	
Foot/Toe Pain	Sore/Weak Muscles	Walking Problems	
Restricted Movement ~ Leg/Foot	Pain around Collar Bone		
Restricted Movement ~ Shoulder/Arm/Hand			
Swollen/Painful/Stiff Joints ~ Leg/Foot			



Dr. Mike R. Marcell  
Chiropractic Physician

**Health Record Update:**

NAME- \_\_\_\_\_ DATE- \_\_\_\_\_

PHONE- \_\_\_\_\_ EMAIL- \_\_\_\_\_

**Chiropractic:**

1. Have there been any recent changes to your health? Yes  No
2. Have you had any falls or injuries that may have resulted in broken bones since your last visit? Yes  No
3. Have you had a car accident since your last visit? Yes  No
4. Have any of your family members or friends been recently involved in a car accident? Yes  No
5. Have they been evaluated? Yes  No
6. Do you have a friend or family member that you feel would benefit from chiropractic care? Yes  No

**Nutrition:**

1. Do you currently take vitamins, minerals or herbal supplements? Yes  No
2. If YES do you notice a difference in your health? Yes  No
3. Are you interested in learning more about nutritional supplements? Yes  No
4. Are you interested in a nutritionally based weight loss program that teaches you how to shop, cook, eat and exercise? Yes  No

**Exercise:**

1. I  currently exercise  used to exercise  do not exercise
2. Are you interested in starting to exercise? Yes  No
3. What is your exercise goal?  
 Weight loss       Cardiovascular conditioning  
 Strength Training       Flexibility
4. Do you need a plan or guidance? Yes  No
5. Would you be interested in a free consultation with a licensed personal trainer? Yes  No



### Financial Responsibility Agreement

I, the undersigned, have read and agreed to the following office procedure polices of **Complete Family Chiropractic Health Care**.

1. Payment is expected in full as services are rendered unless prior financial arrangements have been made.
2. The patient is responsible for any portion of an insurance claim which is not paid by their insurance company.
3. Patients involved in legal suits are responsible for any portion not paid by their insurance company. In the event of a legal settlement, all medical bills to **Complete Family Chiropractic Health Care** shall be paid out of settlement funds and before disbursement of settlement funds.
4. Any outstanding balances of thirty (30) days of age or greater are automatically presented to a collections attorney. A 30% fee is assessed to each account and the patient is responsible for all attorney fees and court fees.
5. Payment plans are available and will be privately discussed between the doctor and patient upon the patient's request.

### Financial Responsibility Statement

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt. 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, against the Doctor's recommendations, my account balance will be immediately due and payable.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**Acknowledgement of Receipt of Notice of Privacy Practices**  
*You may refuse to sign this acknowledgement*

The undersigned acknowledges receipt of a copy of the currently effective notice of Privacy Practices for **Complete Family Chiropractic** this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

A copy of this signed, dated acknowledgement shall be effective as the original.

\_\_\_\_\_  
 Printed Name

\_\_\_\_\_  
 Signature

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority: \_\_\_\_\_

Thank you and if you have any questions about this form, please contact our Privacy Officer.

**Office Use Only**

As Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this acknowledgement.

- It was an emergency treatment.
- I could not communicate with the patient.
- The patient refused to sign.
- The patient was unable to sign because \_\_\_\_\_
- Other (please describe) \_\_\_\_\_
- Signature of Privacy Officer \_\_\_\_\_