



MIDTOWN LIFE STUDIO

PATIENT INFORMATION AND HISTORY

1 Date: _____

PATIENT INFORMATION

Name: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____ Age: _____

Male Female _____ Sex at birth: _____

Cell phone: _____

Email: _____

How did you hear about our office? _____

Occupation: _____

Employer: _____

Parent's Name (If a minor): _____

Single Married Divorced Widowed Partnered

Spouse/Partner's Name: _____

of Children: _____ Name(s): _____

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

Name: _____ Relationship: _____

Home #: _____ Cell: _____

2 ACCOUNT INFORMATION/INSURANCE

Who is financially responsible for this account? _____

Relationship to patient: _____

Patient's insurance company: _____

Subscriber's name: _____

Relationship to patient Self Spouse Parent Other

Subscriber's date of birth: _____

Insurance ID number: _____

Group/Claim number: _____

Is patient covered by Medicare? Yes No

Is patient covered by additional insurance? Yes No

Insurance company: _____

Secondary Ins ID number: _____

Secondary Ins group number: _____

Is your condition due to an accident? No Yes Date: _____

Type of accident? Auto Work Home Other

To whom have you reported the accident?

Your auto insurance Employer Other

Please provide ID and insurance card(s) so we may scan in to your file.

3 PATIENT CONDITION

PRIMARY complaint (List only one): _____

When did this condition begin? _____ Was this condition the result of an accident or injury? Yes No

Please describe the cause of your current complaint: _____

Have you had this problem before? Yes No If yes, when: _____

How often do you feel it? Constant Daily Comes and goes

How does it feel? Burning Sharp Shooting Dull Aching

Stiff Tingling Throbbing Swelling Other _____

Circle below the severity of your pain on a scale of 0 to 10:

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

What makes your condition better? _____

What makes your condition worse? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities/movements that are painful/difficult to perform:

Sitting Standing Walking Bending Lying down Driving Other: _____

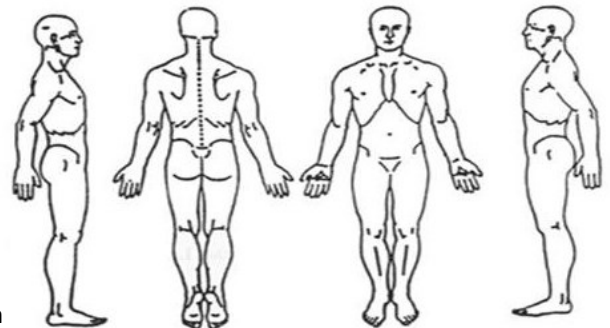
What other treatment have you had for this condition? Chiropractic Medical Physical Therapy Surgery Other

Please describe the other doctor's treatment for your condition: _____

Previous chiropractic care? No Yes Date: _____ Local Out of state: _____ Duration of treatment: _____

Is there anything else you would like the doctor to know about this condition? _____

Please mark where it hurts



PATIENT CONDITION (Continued)

SECONDARY complaint (list only one): _____

When did this condition begin? _____ Was this condition the result of an accident or injury? Yes No

Please describe the cause of your current complaint: _____

Have you had this problem before? Yes No If yes, when: _____

How often do you feel it? Constant Daily Comes and goes

How does it feel? Burning Sharp Shooting Dull Aching

Stiff Tingling Throbbing Swelling Other _____

Circle below the severity of your pain on a scale of 0 to 10:

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

What makes your condition better? _____

What makes your condition worse? _____

Does it interfere with your Work Sleep Daily Routine Recreation

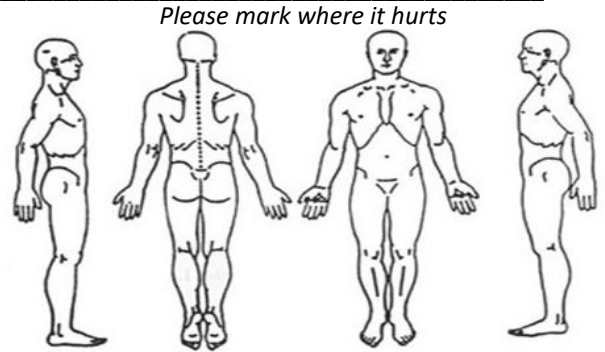
Activities/movements that are painful/difficult to perform:

Sitting Standing Walking Bending Lying down Driving Other: _____

What other treatment have you had for this condition? Chiropractic Medical Physical Therapy Surgery Other

Please describe the other doctor's treatment for your condition: _____

Previous chiropractic care? No Yes Date: _____ Local Out of state: _____ Duration of treatment: _____



If you have any additional complaints, please let your doctor know during the exam.

What are your top 3 health goals?

1.) _____

2.) _____

3.) _____

Is there anything else you would like the doctor to know? _____

PERSONAL HEALTH HISTORY

Check any of the following conditions you have had:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mid/low back pain | <input type="checkbox"/> Sleep issues |
| <input type="checkbox"/> Allergies/Sinus | <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tiredness/Fatigue |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches—Migraine | <input type="checkbox"/> Gluten Intolerance | <input type="checkbox"/> TMJ/jaw pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Vertigo/dizziness |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herniated disc | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Shingles | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Digestive issues | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Sinus infections | |
| <input type="checkbox"/> Ear ringing/pain | <input type="checkbox"/> Leg/knee pain | | |
| <input type="checkbox"/> Other _____ | | | |

Males:
 Prostate problems

Females:
 PMS/Irregular cycle
 Infertility

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Stressors:

- () Smoking Packs/day: _____
- () Coffee Cups/day: _____
- () Alcohol Drinks/week: _____
- () High stress level Reason: _____

Exercise:

- () None () Moderate () Daily () Heavy

Digestion:

Do you have any food sensitivities that you know of? () Y () N If yes, please list them:

How often do you have a bowel movement? _____

Do you experience constipation? () Y () N Diarrhea? () Y () N If yes to either, please describe:

How long have you been dealing with this? _____

Sleep:

How many hours of sleep do you get each night? _____

Do you wake up feeling rested? () Y () N

Do you have difficulty falling asleep? () Y () N

Do you have difficulty staying asleep? () Y () N

Medications/Supplements:

List any medications you are taking:

_____	_____
_____	_____
_____	_____
_____	_____

Vitamins/herbs/minerals:

_____	_____
_____	_____
_____	_____

Females:

Are you pregnant? () Yes () No () Possibly

Beginning date of last menstrual cycle: _____ Length of menstrual cycle: _____

Do you experience PMS symptoms? _____ If yes, please describe: _____

Are you peri-menopausal? () Yes () No Post-Menopause? () Yes () No If yes, how long _____

Have you had any:

Description

Date

Automobile/work related accidents: _____	_____
_____	_____
Surgeries: _____	_____
_____	_____
_____	_____
Broken bones: _____	_____
_____	_____
Falls/Head injuries: _____	_____
_____	_____

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FAMILY HEALTH HISTORY

Please review the diseases and conditions listed below.

- Indicate CURRENT health issues of a family member with a "C".
- Indicate PAST health issues of a family member with a "P".
- Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	Siblings		Children		
	Age	Age	Age	Age	Age	Age	Age	Age
ADHD								
Allergies								
Arthritis								
Asthma								
Autism								
Back Trouble								
Bed Wetting								
Bursitis								
Cancer								
Chest Pain								
Colic								
Constipation								
Crohn's Disease								
Depression								
Diabetes								
Diarrhea								
Disc Problems								
Down Syndrome								
Ear Infection								
Emotion Issues								
Emphysema								
Epilepsy								
Headaches								
Migraines								
Heartburn								
Heart Trouble								
High Blood Pressure								
IBS								
Indigestion								
Infertility								
Insomnia								
Kidney Trouble								
Neck Pain								
Neuritis								
Nervousness								
Pinched Nerve								
Scoliosis								
Sinus Trouble								
Other								

Additional Comments:

Thank You!

PRIVACY POLICY/HEALTH CARE AUTHORIZATION

THE PERSON IDENTIFIED BELOW AUTHORIZES Dr. Chris Peterson and Midtown Life Studio, TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to Midtown Life Studio to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about health care or other health related information

If Midtown Life Studio contacts me by phone, I give permission to leave a phone message or voicemail

I give Midtown Life Studio permission to adjust me in an open room where others are also being adjusted. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time privately, the doctor will provide a room for these conversations

By signing this form, you are giving Midtown Life Studio permission to use and disclose your Protected Health Information in accordance with the directives listed above.

The use of this format is intended to make your experience at Midtown Life Studio more efficient and productive and enhance your access to quality Chiropractic care and health information. This authorization will remain in effect for the duration of my care at Midtown Life Studio plus 10 years unless specifically revoked by me.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION in writing at any time. However, your written request to revoke this AUTHORIZATION is not effective retroactively and is only effective starting on the date it is received by Midtown Life Studio.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to Midtown Life Studio. The written notice must contain the following personal information: Your full name, social security number, date of birth, a clear statement of your intent to revoke this AUTHORIZATION; the date of your request, and your signature.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Midtown Life Studio will not refuse to provide care. You have the right to inspect/copy the protected health information to be used/disclosed. A copy of this signed form will be provided upon request.

I understand and agree to the AUTHORIZATION above.

Signature of Patient _____ Date _____

Name (Please Print) _____

Date of Birth _____

Signature of Personal Representative/Parent (if needed) _____

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Please read all three sections carefully and sign in EACH section

AUTHORIZATION AND AGREEMENT FOR PAYMENT OF SERVICES RENDERED

It is the policy of Midtown Life Studio to collect on the day of service for all services as they are rendered, unless other financial arrangements are made. **I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT.** As a courtesy, the office will submit claims to my insurance for all services and assist me in receiving any out-of-network benefits that I may be entitled to. I authorize Midtown Life Studio to release information regarding my treatment to any insurance company, attorney, and/or adjustor in order to process any claims for reimbursement of charges incurred by me.

Print Patient's Name

Date

Signature (if minor, parent's signature)

Acknowledgement of Midtown Life Studio's Privacy Practices

I acknowledge that this office's Notice of Privacy Practice's has been made available to me either online or in the office. I also understand that this Notice is available by request.

Print Patient's Name

Date

Signature (if minor, parent's signature)

**Midtown Life Studio's
Informed Consent for Examination and Treatment**

This document explains some potential risks associated with chiropractic care. Please read this information carefully and let our staff know if you have any questions. The doctors and staff of Midtown Life Studio will do everything to assist you with your health or your condition. Please be aware that, as with all healthcare systems, we cannot guarantee a cure or resolution of your problem. While chiropractic care is remarkably safe, there are some associated risks. We feel that you need to be fully informed about these risks before consenting to treatment.

- **Soreness** – Chiropractic adjustments and associated therapies may sometimes cause post-treatment soreness. While soreness is usually mild and temporary, please tell your doctor if you experience this.
- **Soft Tissue Injury** – Rarely, chiropractic treatment may aggravate a disk injury, or cause other minor joint, ligament, tendon or other soft tissue injury.
- **Rib Injury** – Adjustments to the mid back, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk for fracture. Treatment is performed carefully to minimize such risk.
- **Stroke** – Stroke is the most serious complication of chiropractic care, but fortunately its occurrence is extremely rare. The most recent studies estimate that the incidence of stroke is one in five million neck adjustments.
- **Other Complications** – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

We will make every reasonable effort during examination to screen for potential risks. Please be aware that if you have a condition that would otherwise not come to our attention, it is your responsibility to inform the doctor.

I, the undersigned, agree that I have read, or have had read to me, and understand the information stated above. I hereby authorize the doctors and staff of Midtown Life Studio to perform examination procedures and administer treatment to me, or to the person listed below for whom I serve as legal guardian. I understand that all procedures and treatment will be explained to me before they are performed, and that I have the right to refuse any such procedures.

Print Patient's Name

Date

Signature (if minor, parent's signature)

