PATIENT DATA SHEET

General Information

First Name _____
Middle Initial _____
Last Name _____
Suffix _____
Called Name _____
Address _____
City _____
State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____

Sex Male Female
Marital Status Single Married Other _____
Birthdate _____
Social Security XXX-XX-_____ Last 4 numbers

Referred By _____

Work Status Employed Full-time student Part-time student

I prefer to receive Appointment Reminders by___ text or ___email

I prefer to receive other communication by ___ text ___phone or ___email

(This includes follow-ups by the Dr., inclement weather rescheduling, etc.)

If you would like to receive promotional material, please sign up for our newsletter at www.colechirotulsa.com or follow us on Facebook @Cole Chiropractic Clinic!

Insured's Information

Patient is the Self Husband Wife Child Other of Insured

First Name _____

Middle Initial _____

Last Name _____

Address _____

City, State, Zip _____

Phone Number _____

Social Security _____

Date of Birth _____

Sex Male Female Unknown

Employer Information

Employer_____

Address_____

City, State, Zip_____

Patient Intake Form

Name: ___________________________________

Are your present problems due to an injury? ❑Yes ❑No Enter the date of the injury: ______________________________

Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: ______________________________________

Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other: ___________

Briefly describe what caused the pain (accident, injury or illness):____

____

____

____

List symptoms experienced **immediately**: Choose the severity level associated with each symptom

_____________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain ❑Occasional ❑Intermittent ❑Frequent ❑None

Type of Pain ❑Aching ❑Burning ❑Dull ❑Pulling ❑Sharp ❑Shooting ❑Stabbing ❑Stinging ❑Throbbing ❑None

_____________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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List any tests, studies or medications received for **this** condition:

❑Tests/Studies: ____

❑Medications: ____

Where you admitted to the hospital due to this condition: ❑Yes ❑No

If yes, what hospital? ____________________Transported by? ❑Ambulance ❑Police ❑Other: __________________

Date Admitted: ______________ Date Released: ___________ Length of Stay: _____________

List the hospital procedures received: ____

List symptoms you are experiencing **today**: Choose the severity level associated with each symptom

____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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Do you have any current work restrictions due to this condition?

Off work: ❑Yes ❑No ❑Previously From: ____________________ To: ____________________

Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) ____________________________________

What type of work do you do?____

____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No ______________________

____

HABITS

❑Current Every Day Smoker ❑Current Some Days Smoker

❑Former Smoker ❑Never Smoker

❑Drinking Alcohol: (Cups/day): _____ ❑Coffee Cups/Day: _______

❑Soft Drink Bottles or Cans/Day: _____ ❑Water Cups/Day: _______

EXERCISE

❑None
❑Moderate
❑Daily

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other	
Mother	❑	❑	❑	❑	_____
Father	❑	❑	❑	❑	_____
Sibling(s)	❑	❑	❑	❑	_____

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No

If Yes, please indicate the following:

Medication: _____
Route: Oral / Intravenous / Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

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Discontinued Use: _____

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Route: Oral / Intravenous / Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: _____

Do you have allergies to medication? ❑Yes ❑No

If Yes, please indicate the following:

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

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Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

DATE		DATE		DATE	
_____	Back Operation	_____	Hernia	_____	Gall Bladder
_____	Female Organs	_____	Thyroid	_____	Stomach

Other surgery and date _____

Have you ever had X-rays taken in the last year? ❑Yes ❑No When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

OPERATIONS AND PROCEDURES

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS

- ❑ Allergy(What) ____ _____
- ❑ Bronchitis
- ❑ Chills (Constant)
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands
- ❑ Wheezing

GASTRO-INTESTINAL

- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux
- ❑ Irritable Bowel

EYE/EAR NOSE/THROAT

- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats
- ❑ Tonsillitis

RESPIRATORY

- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination
- ❑ Prostate Trouble

MUSCLES & JOINTS

- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain Between Shoulders
- ❑ Painful Tail Bone
- ❑ Stiff Neck
- ❑ Spinal Curvature
- ❑ Swollen Joints

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation
- ❑ Rapid Heart
- ❑ Slow Heart
- ❑ Strokes
- ❑ Swelling Ankles

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching
- ❑ Sensitive Skin
- ❑ Skin Eruptions

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ Pregnant Now?

_____ Last Pap Date

_____ Last Menstrual Cycle

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any services he deems necessary in my case; and I further authorize him to disclose all or any part of my patient 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. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I understand that this chiropractic 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 to Cole Chiropractic Clinic PC will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment.

Patient's/Guardian's Signature: _____ Date: _____

Cole Chiropractic Clinic, P.C.

PATIENT AUTHORIZATION

FOR THE USE AND DISCLOSURE

OF PROTECTED HEALTH INFORMATION

1. I, _____, hereby authorize Cole Chiropractic Clinic, P.C., (the "Practice") to use and/or disclose patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care.
2. I understand that this authorization is valid indefinitely for the purposes stated.
3. I understand that the purpose or use of the disclosure I am granting is: Recognize me for my birthday, or the referral of another person, or a thank you to someone that has referred me to the practice.
4. I expressly acknowledge that this authorization is voluntary.
5. The following is/are other criteria or limitations that I make regarding this authorization:

   _____

   _____
6. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
7. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
8. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
9. I understand that my health care and payment for my healthcare will not be affected if I do not sign this form.
10. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.
11. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.
12. This authorization is valid as of ____/___/___, the date I have signed below.

_____ _____

Name of individual (Printed) Signature of individual

_____ _____

Signature of Legal Representative Relationship

(E.g. Attorney-In-Fact, Guardian, Parent if a minor

_____

Witness