Sunrise
CHIROPRACTIC
Chiropractic, Homeopathy, & Brain Integration

PATIENT INFORMATION

First Name:_____ Last Name:_____ MI:_____

Date of Birth:_____ Social Security #:_____ Sex: F M

Martial Status:_____ Are you a student?

Primary Address:_____

Primary Phone:_____ Email:_____

Employer:_____ Occupation:_____

Spouse's Name:_____ Occupation:_____ Primary Phone:_____

Emergency Contact:_____ Relationship:_____ Primary Phone:_____

Who were you referred by? _____

GUARDIAN OR RESPONSIBLE PARTY ACCOMPANYING PATIENT UNDER THE AGE OF 18

First Name:_____ Last Name:_____ Date of Birth:_____

Primary Address:_____

Primary Phone:_____ Employer:_____ Occupation:_____

Relationship to Patient:_____ Marital Status:_____

INSURANCE (PLEASE PRESENT MEDICAL CARDS FOR PHOTOCOPY)

Primary Company:_____ Company Address:_____

Group #_____ ID #:_____ Policy Holder:_____

Relationship to Patient:_____ Social Security #:_____ Date of Birth:_____

Primary Address:_____
Secondary Company:_____ Company Address:_____

Group #_____ ID #:_____ Policy Holder:_____

Relationship to Patient:_____ Social Security #:_____ Date of Birth:_____

Primary Address:_____

CERTIFICATION OF INFORMATION

By my signature below, I authorize Sunrise Chiropractic Center PC to release any information deemed appropriate to any doctor, insurance company, or attorney in the course of my treatment or in order to process any claim for reimbursement of charges. I hereby assign all the right, title and interest relative to insurance benefits to Sunrise Chiropractic Center PC. I clearly understand and agree that I am personally responsible for payment of all services rendered to me. Further, in the even that my account is turned over for collection, I understand that I will be responsible for any charges, attorney fees, collection costs and court costs incurred in collecting the balance

_____ _____

Patient Signature Date

Sunrise CHIROPRACTIC
Chiropractic, Homeopathy, & Brain Integration

HEALTH HISTORY

Name:_____ DOB:_____ Age:_____ Height:_____
Weight:_____

Are you presently under a physician's care or have you been during the past five years? Y N Date of last exam:_____

Please list any and all medications that you are presently taking (antibiotics, pain meds, heart meds, anti coagulants, vitamins):

Please circle if you've been affected by any of the following conditions:

AIDS/HIV	Diabetes	Liver Disease	Prostate Problems
Alcoholism	Emphysema	Measles	Psychiatric Care
Allergy Shots	Epilepsy	Migraine	Stroke
Anemia	Fractures	Miscarriage	Suicide Attempt
Appendicitis	Goiter	Mononucleosis	Thyroid Problem
Arthritis	Gout	Multiple Sclerosis	Tuberculosis
Asthma	Heart Disease	Mumps	Tumors
Bleeding Disorders	Hepatitis	Osteoporosis	Ulcers
Breast Lump	Hernia	Pacemaker	Whooping Cough
Cancer	Herniated Disk	Parkinson's Disease	Other:_____
Chemical Dependency	High Cholesterol	Pinched Nerve	_____
Chicken Pox	Kidney Disease	Pneumonia	_____

Exercise: None Moderate Daily Heavy

Work Activity: None Moderate Daily Heavy

Habits: Smoking (If yes, how many packs a day? _____) Alcohol Coffee High Stress Level

Injuries:_____

Falls:_____

Broken Bones:_____

Surgeries:_____

Motor Vehicle Accidents:_____

Please list any family history of heart disease, cancer, arthritis, etc:

Please list all allergies:_____

Signature:_____ Date:_____

If minor, parent/guardian signature:_____ Date:_____

Sunrise CHIROPRACTIC
Chiropractic, Homeopathy, & Brain Integration

PATIENT CONDITION

Reason for Visit:_____

When did your symptoms appear:_____

Is this condition getting progressively worse:_____

How often do you have this pain (Please circle): Constant Frequently (50-75% of the day)

Occasionally (25-50% of the day) Intermittently (less than 25% of the day)

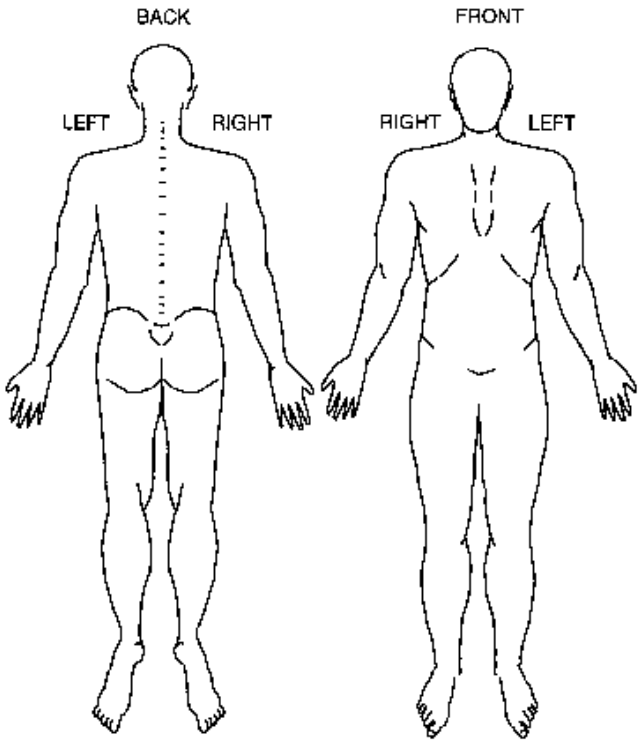
Does it interfere with your: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down

In general would you say that your overall health is: Excellent Very Good Good Fair Poor

Mark the area of your body where you feel the described sensations. Use the appropriate symbols, mark areas of radiating pain and include all affected areas. You may draw in the face as well.

Numbness: -------- Pins & Needles: oooooo Burning Pain: xxxxxx Stabbing Pain: //////// Aching Pain: ((((((



Please mark on the line the pain level that most accurately represents your pain:

NO PAIN	0 1 2 3 4 5 6 7 8 9 10	UNBEARABLE PAIN
Pain Right Now	0 1 2 3 4 5 6 7 8 9 10	_____
Average Pain	0 1 2 3 4 5 6 7 8 9 10	
Pain at Best	0 1 2 3 4 5 6 7 8 9 10	_____

Sunrise
CHIROPRACTIC
Chiropractic, Homeopathy, & Brain Integration

NOTICE OF PRIVACY PRACTICES

The privacy and protection of your patient information is of the utmost importance to SCC. As required by the Federal Health Insurance Portability and Accountability Act (HIPPA) Regulations, a Notice of Privacy Practices must be provided by all health care providers to their patients. At SCC a copy is clipped to the new patient paperwork clipboard and a copy will be provided upon request. SCC reserves the right to modify the privacy practices outlined in the notice.

I authorize SCC to release my protected health information to (Please circle):
Yes_____
(Name of person to whom information may be released other than self, dentist and or physician, i.e. parent, grandparent, spouse)
No
(Self, dentist and or physician)
I have read and understand the Notice of Privacy Practices for SCC and by signing below, acknowledge the same.

Signature of Patient/Legal Guardian Date Relationship to patient if applicable

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment and any alternatives to the treatment. There are some risks that may be associated with treatment. In particular you should note:

1. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment.
2. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustments although no scientific study has ever demonstrated such injuries are caused or may be caused by spinal or soft tissue manipulation or treatment.
3. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.

Osseous and soft tissue manipulation had been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms.

Musculoskeletal care contributes to your overall well being. The risk of injuries or complications from treatment is substantially lower than that associated with many medical treatments, medications and procedures given for the same symptoms.

I acknowledge that I have discussed the following with my health care provider:

1. The condition that the treatment is to address
2. The nature of the treatment
3. The risk and benefits of that treatment
4. Any alternative treatments

I have had the opportunity to ask questions and receive answers regarding the treatment. I consent to the treatments offered or recommended to me by my health care provider, including osseous and soft tissue manipulation. I authorize Dr. Schiller to diagnose and treat my condition as deemed appropriate. I intend this consent to apply to all my present and future care with Sunrise Chiropractic Center PC and Dr. Gwen Schiller, DC.

Dr. Schiller will communicate with you via email, text, and phone. We also use email to send invoices and test, x-ray, lab results. These are considered non-secure methods of communication. By signing below, I agree to these non-secure methods of communication.

Patient Name (Please print)

Patient Signature Date