Eddy Chiropractic Clinic Inc.
443 Highland Ave
Williamstown, WV 26187
304-375-6000

UPDATED CONTACT INFORMATION

Please fill in your name and other demographic information that may need to be changed or updated in our files.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
○ No ○ Yes When?

Whom may we thank for referring you?

If so, whom?

Gender
○ Male ○ Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Marital Status
○ Single ○ Married ○ Divorced
○ Widowed ○ Separated

Address

City

State/Province

ZIP/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Address

State/Zip

Phone

May we contact you at work?
○ Yes ○ No

Preferred method of contact?
○ Home Phone ○ Cell Phone
○ Work Phone ○ Email

PRIMARY INSURANCE INFO

Insured's Last Name

Birth Date (MM/DD/YY)

Insured's Social Security #

Insured's First Name

Middle Name (or Initial)

Who carries this policy?
○ Self ○ Spouse ○ Parent

SECONDARY INSURANCE INFO

Insured's Employer

Employer's Phone

Insured's Last Name

First Name

Middle Initial

Birth Date

Social Security #

Address

City

State/Province

ZIP/Postal Code

Relationship to patient

CONFIDENTIAL HEALTH INFORMATION

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UPDATED PATIENT HISTORY

Today's Date (MM/DD/YYYY) ____________

Your Last Name ____________ Your First Name ____________ Your Middle Name (or Initial) ____________

Height: ____________

Weight: ____________

◯ Have you been involved in an auto accident or work related injury, if so please see the front desk staff immediately.

Please select one:

◯ **Progress evaluation** – I've been under active care and this is a periodic reevaluation.
◯ **New condition** – I've been under care and a new or returning condition has emerged.
◯ **Maintenance patient** – I'm under maintenance care with a new or returning health issue.
◯ **Returning patient** – After a period of inactivity, I've had a relapse or an all-new health issue.

Current symptoms: ____________

1. Location (Where does it hurt?) Circle the area (s) on the illustration.

2. Quality of symptoms (What does it feel like?)

◯ Numbness
◯ Tingling
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Nagging
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other

3. Intensity (How extreme are your current symptoms?)

0 ◯-◯-◯-◯-◯-◯-◯-◯-◯-◯ 10
Absent — Uncomfortable — Agonizing

4. Duration and Timing (When did it start and how often do you feel it?)

◯ Constant ◯ Come and goes.

When did it start and how often? ____________

5. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

____

6. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? ____________

What tends to lessen the problem? ____________

7. Prior interventions (What have you done to relieve the symptoms?)

◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic Other ____________
◯ Physical therapy ◯ Massage ____________

8. What else should Eddy Chiropractic Clinic know about your current condition? ____________

____

____

9. Review of systems (Identify any changes since your most recent evaluation with us):

	Worse	No Change	Improved
a. Musculoskeletal System – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	◯	◯	◯
b. Neurological System – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	◯	◯	◯
c. Cardiovascular System – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.	◯	◯	◯
d. Respiratory System – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	◯	◯	◯
e. Digestive System – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	◯	◯	◯
f. Sensory System – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	◯	◯	◯
g. Skin System – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.	◯	◯	◯
h. Endocrine System– Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.	◯	◯	◯
i. Genitourinary System – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.	◯	◯	◯
j. Constitutional System – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.	◯	◯	◯

10. Illnesses, operations, injuries or treatments since your most recent evaluation with us: ____________

____

____

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11. Social History (Tell Eddy Chiropractic Clinic about your health habits and stress levels.)

Alcohol use	◯ Daily	◯ Weekly	How much?__________
Coffee use	◯ Daily	◯ Weekly	How much?__________
Tobacco use	◯ Daily	◯ Weekly	How much?__________
Exercising	◯ Daily	◯ Weekly	How much?__________
Pain relievers	◯ Daily	◯ Weekly	How much?__________
Soft drinks	◯ Daily	◯ Weekly	How much?__________
Water intake	◯ Daily	◯ Weekly	How much?__________

Hobbies: __________

Prayer or meditation?	◯ Yes	◯ No
Job pressure/stress?	◯ Yes	◯ No
Financial peace?	◯ Yes	◯ No
Vaccinated?	◯ Yes	◯ No
Mercury fillings?	◯ Yes	◯ No
Recreational drugs?	◯ Yes	◯ No

12. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	◯	◯	◯	◯
Rising out of chair	◯	◯	◯	◯
Standing	◯	◯	◯	◯
Walking	◯	◯	◯	◯
Lying down	◯	◯	◯	◯
Bending over	◯	◯	◯	◯
Climbing stairs	◯	◯	◯	◯
Using a computer	◯	◯	◯	◯
Getting in/out of car	◯	◯	◯	◯
Driving a car	◯	◯	◯	◯
Looking over shoulder	◯	◯	◯	◯
Caring for family	◯	◯	◯	◯

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	◯	◯	◯	◯
Household chores	◯	◯	◯	◯
Lifting objects	◯	◯	◯	◯
Reaching overhead	◯	◯	◯	◯
Showering or bathing	◯	◯	◯	◯
Dressing myself	◯	◯	◯	◯
Love life	◯	◯	◯	◯
Getting to sleep	◯	◯	◯	◯
Staying asleep	◯	◯	◯	◯
Concentrating	◯	◯	◯	◯
Exercising	◯	◯	◯	◯
Yard work	◯	◯	◯	◯

13. Is there anything else Eddy Chiropractic Clinic should know about your current condition, your progress or ways your current condition is affecting your life?

____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: __________

Signature __________ Date (MM/DD/YYYY) __________

List any updated Medications

____

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CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you are granting consent to Eddy Chiropractic Clinic INC. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by: contacting us at (304) 375.6000. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

____

Patient Name (Please Print)

____ ______________________

Signature Date

If you would like the option of being able to have your spouse, parent, or other individual to discuss your account with us please fill in the form below and sign. If our office does not have signed permission by you we will be unable to honor any request for information from any of these parties. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

I, ____, grant permission to Eddy Chiropractic Clinic INC. to release information concerning my account to the person(s) listed below.

☐ ____________________________________ Spouse
Name

☐ ____________________________________ Parent(s)
Name

☐ ____________________________________ Other ____________________
Name Relationship (optional)

☐ Medical Only ☐ Accounting/Billing Information Only ☐ All

____ ______________

Signature Date

EDDY CHIROPRACTIC CLINIC
443 HIGHLAND AVENUE, WILLIAMSTOWN, WV. 26187
304-375-6000

INSURANCE INFORMATION

In this office, our major concern is to assist you in maintaining overall good health. Insurance policies can differ greatly in terms of deductible, percentage of coverage for chiropractic and the allowed number of visits. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, charges that may exceed your coverage, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and we will bill your insurance company(ies) in a timely manner. However, ***we strongly recommend that each patient contact their own insurance company to verify their individual coverage***. We will be happy to answer any questions you may have about your insurance benefits.

As a courtesy to our patients, not only do we verify the patient's insurance benefits but we also meet with the patient to explain the benefits that have been provided by the insurance company. Please note that our verification is not a guarantee of payment by your insurance company. Our office does not guarantee quotes provided by your insurance company. Please note, it is the patient's responsibility to know if their insurance requires a referral or any type of paperwork prior to their visit.

________________________________ __________________________

Patient's Signature Date