Sorell-Iversen Chiropractic Clinic

Patient Health History

Today's Date [/ /] **Signature of Patient** ______________________

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name______________________**Middle**____________ **Last Name**______________________

Address 1 ____

City______________________________ **State**__________ **Zip Code** ______________

Primary Phone ______________________**Cell Phone** ______________________

Home email ______________________ **Work Email** ______________________

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth [/ /] **Age** ______ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** ______________________

Spouse's Name ______________________**Spouse's SSN** ______________________

Spouse's Cell Phone ______________________**Spouse's Work Phone** ______________________

Whom May We Contact In Case Of Emergency ______________________**Phone** ______________

Patient Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑Samoan ❑ Guamanian or Chamorro ❑Other________ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Continued …

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Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the Chosen question: ______________________________

Other Than Yourself, Whom May We Share Your Medical Information With?

Spouse ❑ Yes ❑ No__________ **Parent** ❑ Yes ❑ No __________ **Other** ❑ Yes ❑ No __________

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

Current medications and supplements, including dosage if known.
If there are no current medications or supplements, check here: ❑

1) ______________________ 5) ______________________

2) ______________________ 6) ______________________

3) ______________________ 7) ______________________

4) ______________________ 8) ______________________

List any known allergies you have had to any medications.
If no medical allergies are known, check here: ❑

1) ______________________ 3) ______________________

2) ______________________ 4) ______________________

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: __________

____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: ______________________________

***** Briefly list any major area of complaint and any other health problems you would like to discuss:*****

____

Do you drink any alcohol? ❑ Yes ❑ No **How much do you drink?** ______________________

Have you had any previous surgeries? ❑ Yes ❑ No **For What Condition?** ______________________

Date of Your Surgery? ____________ Surgeon's Name ____________

Diet (Do you eat healthy foods?) ❑ Yes ❑ No Exercise regularly? ❑ Yes ❑ No ____________

Any Eye Problems? ❑ Yes ❑ No ______ Hearing Problems? ❑ Yes ❑ No____________

Do You Have Occupational Stress? ❑ Yes ❑ No Physical Stress ❑ Yes ❑ No____________

Hobbies/Sports Injuries? ❑ Yes ❑ No ____________

Have You Ever Received Chiropractic Care? ❑ Yes ❑ No

Other Traumas or Problems? ____________

What Positions do you sleep in? ❑ SIDE ❑ STOMACH ❑ BACK

Was This Condition the Result of an accident? ❑ Yes ❑ No

If yes, was the accident ❑ Car Accident ❑ Home-related ❑ Work-related ❑ Other

Briefly describe the circumstances of the accident ____________

____

Have you been in any previous accidents? ❑ Yes ❑ No

Is your pain: ❑ SHARP ❑ DULL ❑ CONSTANT ❑ INTERMITTENT

What activities aggravate your condition/pain? ____________

What activities lessen your condition/pain? ____________

Is your condition worse during certain times of the day? ❑ Yes ❑ No When? ____________

Is your condition progressively worse? ❑ Yes ❑ No

Is this condition interfering with? ❑ WORK ❑ SLEEP ❑ ROUTINE ❑ OTHER

What home remedies have you tried? ____________

Are you currently being seen for another condition? ❑ Yes ❑ No

If yes, please explain ____________

Name of Primary Physician ____________ Phone ____________

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Is there a Family History of:

Mother's Side	❑ CANCER	❑ ARTHRITIS	❑ HEART DISEASE	❑ DIABETES
Father's Side	❑ CANCER	❑ ARTHRITIS	❑ HEART DISEASE	❑ DIABETES

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

Authorization And Release: I give my consent to Sorell-Iversen Chiropractic to use and disclose my protected health information for purposes of treatment and/or payment of my claims. I also assign the claim payment to be made payable to Sorell-Iversen Chiropractic Clinic. I understand that I am responsible for all costs of chiropractic treatment, regardless of Insurance/Medicare/Medigap coverage.

Patient Signature____ Date____________________

Parent/Guardian ____ Date____________________

To be performed by clinic staff:

Height: ______inches Weight: __________ pounds BP: _______ / _______

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Sorell-Iversen Chiropractic Clinic

630 Poyntz Avenue

Manhattan, KS 66502

(785) 776–7568

Sean A. Sorell D.C.
Scott D. Iversen D.C.

PATIENT INFORMATION

Patient Name ____________________

Patient Address ____________________

City ____________ ST ____ Zip ____

Home Phone No ____________ Work Phone No ____________

Social Security No ____________ Date of Birth ____________

M ______ F ______

Authorization and Release: I authorize payment of Insurance/Medicare/Medigap benefits to Sorell-Iversen Chiropractic. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic treatment, regardless of Insurance/Medicare/Medigap coverage.

Signature of Patient or Insured ____________________

PATIENT INSURANCE INFORMATION

Primary Insurance Co ____ Policy No ____ Group No ____

Primary Insurance Phone No ____________________

Policyholder's Name ____________ Date of Birth ____________

Policyholder's Social Security No ____________________

Policyholder's Relationship to Patient ____________ Phone No ____________

Secondary Insurance Co ____ Policy No ____ Group No ____

Secondary Insurance Phone No ____________________

Policyholder's Name ____ Date of Birth ____ Soc.Sec.No ____

Policyholder's Relationship to Patient ____________________

(OFFICE USE ONLY)
PATIENT ELIGIBILITY AND BENEFITS INFORMATION

Call Date: ______________ **Time of Call:** ______________ **Name of Insurance Rep:** ____________________

Effective Date of Coverage: ______________ Benefit Period: ____________________

Plan Type: HMO ______ PPO ______ POS ______ Other: ______

In-Network Benefits: Co-Payment $______________ Deductible ______________ Deductible Met So Far ____________

Co-insurance $____________ Out of Pocket $______________ Max Yearly Visits ________ Max Yearly $$ ____________

Is a Referral Necessary? Yes ______ No ______

Is Prior Authorization Required? Yes ______ No ______ Prior Authorization Phone No____________________

Of Visits Authorized ____________________ Authorization # ____________________

Out of Network Benefits: Co-Payment $______________ Deductible ______________ Deductible Met So Far ____________

Co-insurance $____________ Out of Pocket $______________ Max Yearly Visits ________ Max Yearly $$ ____________

Notes: ____

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