Canyon Springs Chiropractic Health Center ● 2167 Village Park Ave. Ste. 100 ●Twin Falls, ID 83301
Phone: (208) 737-1430 Fax: (208)737-4225

Patient Information

Name:___________________________________ Age:_______ Today's Date____________

Address: ____ City:___________________

State: _____ Zip: _______ Home Phone: (   )____________Cell Phone: (   )_______________

Social Security #:________________________________ Birth Date: ____________________

Employer: _________________________________ Work Phone: (   )_____________________

Name of Spouse: __________________________________ Patient Gender M F

Emergency Contact (someone *not* living with you):

Name: ___________________________________ Phone #: (   )_______________________

How did you hear about our office? If someone referred you to us, please include their first and last name. ____

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my medical records.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, auto-med, third party liability, and other health plans to: CANYON SPRINGS CHIROPRACTIC HEALTH CENTER.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance after 90 days. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed____ Date _________________________

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Medical History

Patient's Name: ____ Date: __________________

Is your condition due to an accident? __________

Date symptoms began: _____________If caused by an accident, how did it happen?

____

____

____

Symptoms in order of severity and character:

1. ____
2. ____
3. ____
4. ____

Do your symptoms keep you from doing anything you could normally do?___________________

____

Are the symptoms increasing? ______________ Do the symptoms come and go? ______________

What makes your symptoms better or worse? ____

____

Have you ever had these symptoms before?____

What have you tried already to improve your symptoms? ________________________________

____

____

Any history of illness or accidents? ____

When did you last go to a healthcare provider? ____

What medications or supplements are you taking? ____

____

Have you ever had X-rays/MRI? ______________________ Date ____________________________

Any surgeries, regardless of how minor? ____

Allergies? ____

Any family history of illnesses or serious health conditions? ________________________________

____

Do your symptoms affect your sleep? ___________ Work? _________ Exercise? _____________

Have you ever been to a chiropractor? _____________________ Acupuncturist? ______________

On a scale of 1 (least stressful) to 10 (most stressful), how stressful has your life been over the past 30 days? (Circle one) 1 2 3 4 5 6 7 8 9 10

Signature: ____