CONFIDENTIAL PATIENT HISTORY

Name _____ Date ___/___/_____ Date of Birth ___/___/_____

Address _____ City _____ State ____ Zip _____

Phone (H) _____ (W) _____ (C) _____ Sex ___M ___F

Occupation _____ Employer _____ Referred By _____

Past Chiropractic Care _____

Emergency Contact _____ Relationship _____ Phone _____

Payment Preference: Self Pay___ Insurance___ Medicare___ Personal Injury___ Other_____

Insurance Co _____ Insured Name _____ DOB _____

Social Security Number _____ Driver's License Number _____ State ___

Is your present problem due to an injury? ___No ___Yes ___Work ___Auto ___Other:_____

Has the injury been reported? ___No ___Yes ___To Employer ___Auto Carrier ___Other:_____

Have you retained an attorney? ___No ___Yes Name & Phone _____

1. **Describe your symptoms.** _____

   _____

   When did your symptoms begin? _____

   How did your symptoms begin? _____

   Past episodes? _____

2. **How often do you experience your symptoms?**

   ___Constantly (76-100%of the day) ___Frequently (51-75% of the day)

   ___Occasionally (26-50% of the day) ___Intermittently (0-25% of the day)

3. **Describe the nature of your symptoms.**

   __Sharp __Dull ache __Numb __Shooting __Burning __Tingling __Throbbing __Stiffness

4. **Are your symptoms?** ___ getting worse ___ not changing ___ getting better

5. **Average intensity of your symptoms.** Mild 1---2---3---4---5---6---7---8---9---10 Severe

6. **What makes the symptoms worse?** _____

   What makes the symptoms better? _____

7. **How much of the time has the condition interfered with your...**

   ...work: All the time ___ Most ___ Some ___ A little ___ None ___

   ...sleep: All the time ___ Most ___ Some ___ A little ___ None ___

   ...hobbies: All the time ___ Most ___ Some ___ A little ___ None ___

8. **Who have you seen for your condition?** _____

9. **Rate your overall health?** ___ Excellent ___ Very good ___ Good ___ Fair ___ Poor

10. **List any significant medical conditions, medications, medical history, and family history?**

    _____

    _____

    _____

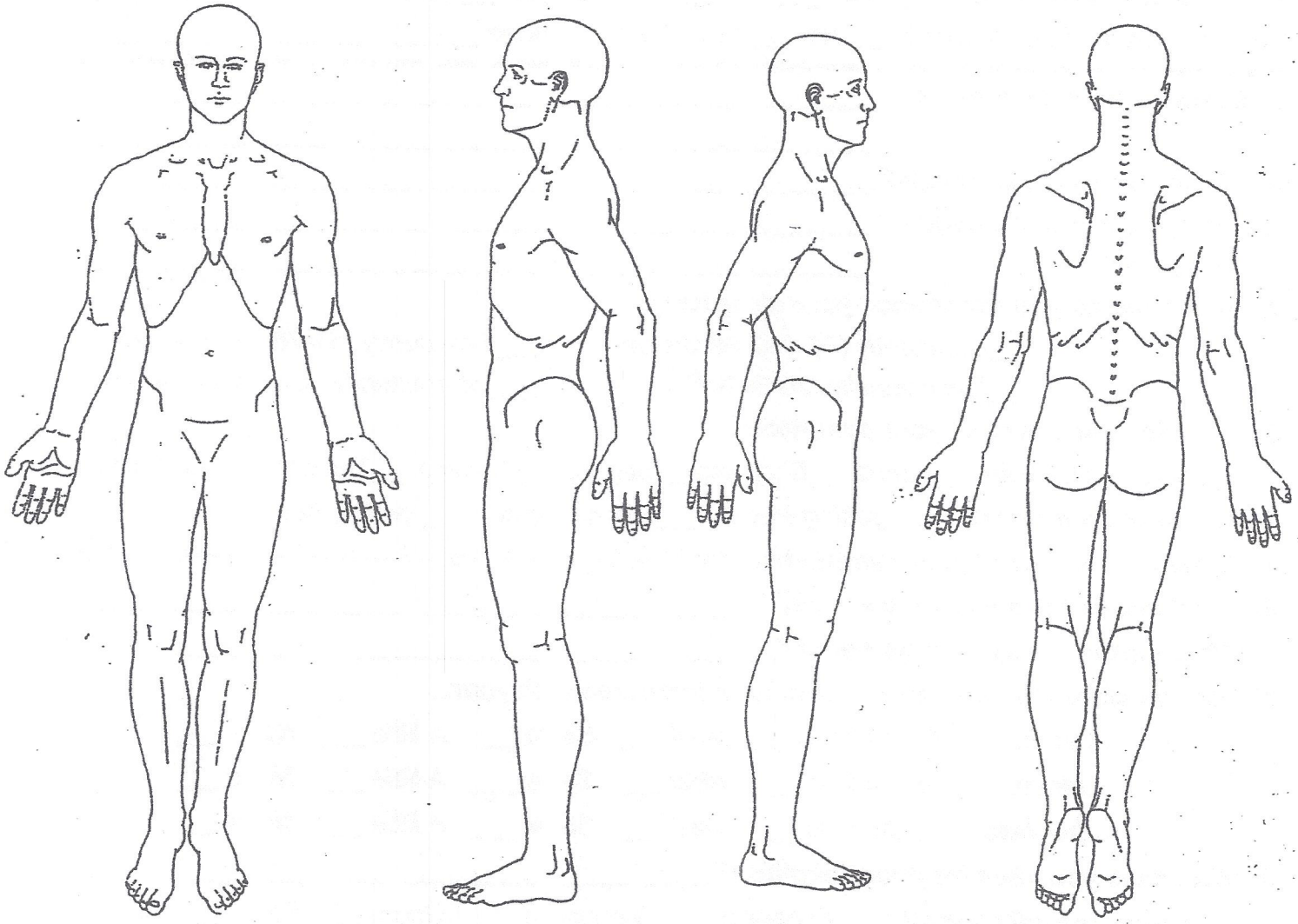
PAIN DRAWING

A precise drawing of your symptoms is a valuable aid in locating the exact source or cause of your problem. This increases the probability of a rapid, long term resolution of your condition.

PLEASE BE PRECISE AND THOROUGH.

Please mark the location and type of pain on the drawings with the codes below.

***S**-Sharp **A**-Ache **B**-Burn **N**-Numb **T**-Tingle **TH**-Throb **ST**-Stiff*



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

CONSENT FOR TREATMENT & ASSIGNMENT

I authorize Dr. Robert P. Saxon and whomever he may designate as his assistant to provide treatment as he deems necessary. I understand, as with any treatment, no specific result or benefit is guaranteed. I assign payment directly to Dr. Saxon for services provided and I am responsible for any deductibles, copay, or unpaid balance to Dr. Saxon.

X _____ _____

Signature Date Witness Signature Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information to process my insurance claim(s) and also certify that all insurance given to this clinic is correct and complete.

X _____ _____

Signature Date Witness Signature Date

MASSAGE THERAPY CANCELLATION/MISSED APPOINTMENT POLICY

As massage therapy services are provided by appointment only and this time is reserved for your exclusive use, we must require 24 hours notice to cancel an appointment. This will allow us to offer the appointment time to another client or you will be charged a $45.00 cancellation fee. If using a Gift Certificate and the appointment is missed, without 24 hours notice, you forfeit the use of that particular certificate. Thank you for your consideration.

X _____ _____

Signature Date Witness Signature Date

HEALTH CARE AUTHORIZATION

I give permission to Windy Hill Chiropractic Center to contact me with appointment reminders, missed appointment notification, birthday/holiday cards, newsletters or other health related information.

X _____ _____

Signature Date Witness Signature Date

HIPPA NOTICE

I have read and understand the Notice of Privacy Practices for Protected Health Information.

X _____ _____

Signature Date Witness Signature Date