Chiropractic Physicians Center of Tupelo
CONFIDENTIAL PATIENT INFORMATION
(Please Print)

Date: _____ E-mail Address _____
Full Name: _____
Name of Wife, Husband or Guardian: _____
Address: _____
City _____ State _____ Zip Code _____

Telephone Number ( ) _____ Cell Phone Number ( ) _____
Social Security No. ____--____--____
Birth date: _____ No. of Children _____ Currently Pregnant? _____
Marital Status: S___ M___ D___ W___ Student: No ____ Part time _____ Full time____
Occupation: _____
Employer's Name / Phone # : _____
Spouse's Occupation / Employer: _____
Name and phone # of Emergency Contact: _____
How did you hear about our office? _____

List Chiropractors you have seen before:

1. Name: _____ When visited: _____
2. Name: _____ When visited: _____

List Medical Doctors consulted within the past year:

1. Name: _____ Reason for visit? _____
2. Name: _____ Reason for visit? _____

Please list all your reasons for visiting our office:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List ***ALL*** medications you take. (Prescriptions and over-the-counter – use additional pages if needed)

Drug name:	Dosage:	How long have you taken this and for what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

List ***ALL*** nutritional supplements you take. (Use additional pages if needed)

Name of Supplements:	Dosage:	How long have you taken this and for what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

List ***ALL*** previous hospitalizations, surgeries, accidents, fractures and illnesses. (use additional pages)
(Example: **All past** Auto, Sports, Work, Home related).

1. Type _____ When _____ Hospitalized? Yes _____ No _____
2. Type _____ When _____ Hospitalized? Yes _____ No _____
3. Type _____ When _____ Hospitalized? Yes _____ No _____
4. Type _____ When _____ Hospitalized? Yes _____ No _____

Patient Name: _____

Check **ALL** "body signals" (symptoms/pain) you may have had or do have now:

___ ADD/ADHD	___ Depression	___ Hepatitis	___ Miscarriage
___ Alcoholism	___ Diabetes	___ High Blood Pressure	___ Multiple Sclerosis
___ Allergy	___ Diarrhea	___ High Cholesterol	___ Neck pain
___ Alzheimer's	___ Eczema	___ High Blood Sugar	___ Parkinson's Disease
___ Anemia	___ Emphysema	___ HIV/AIDS	___ Pneumonia
___ Appendicitis	___ Epilepsy/seizures	___ Irregular Periods/Cramps	___ Raynaud's
___ Asthma	___ Fibromyalgia	___ Irritable Bowel	___ Rheumatoid Arthritis
___ Arthritis	___ Gall Bladder	___ Kidney infections/stones	___ Ringing in Ears
___ Back pain	___ Goiter	___ Low Blood Pressure	___ Sinus infections
___ Cancer	___ Gout	___ Low Blood Sugar	___ Stroke
___ Celiac/Gluten Dis.	___ Headaches	___ Lyme Disease	___ Thyroid Problems
___ Chronic Fatigue	___ Heart Attack	___ Lupus	___ Ulcers
___ Constipation	___ Heart Disease	___ Migraine	___ Vertigo/dizziness

Please Check all of the following conditions your family has experienced.

Mother:	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
Father:	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
GrandMother (M):	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
GrandFather (M):	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
GrandMother (P):	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
GrandFather (P):	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
Sisters:	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
Brothers:	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	

List any other health conditions that you or your family have had that are not listed: _____

Do you consume any of the following? (leave blank what doesn't apply)

Tobacco products (packs/day) ___ How many years? ___ Alcohol drinks/day___ How many years? ___

Coffee/Tea cups/day ___ Regular or decaf? ___ Soft Drinks # day ___ Regular or diet? ___

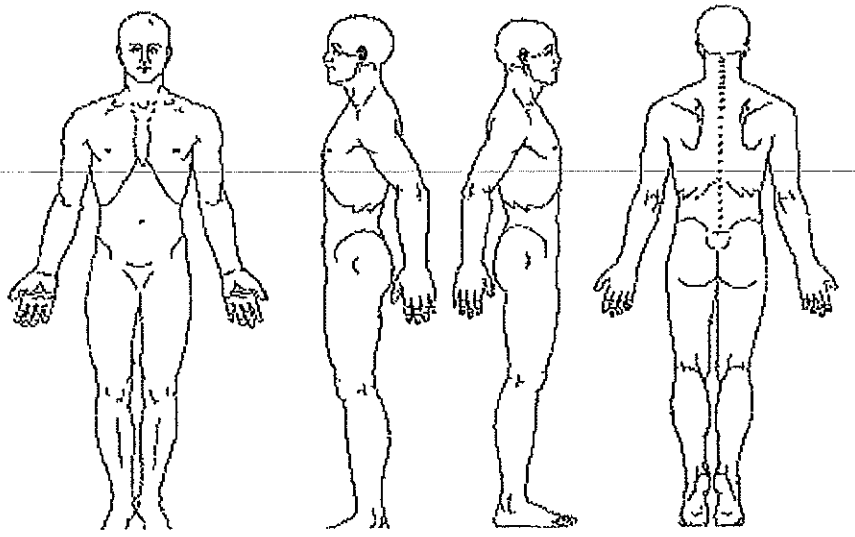
Do you use artificial sweeteners?___ Yes ___ No If yes please list? _____

Level of exercise? ___ None ___ Moderate (days per week) ___ ___ Strenuous (days per week) ___

Have you experienced any unexplained or rapid weight changes in the last six months? ___ Yes ___ No ___ lbs

Please mark off the areas of your complaint on the diagram below. Use the following symbols:

P = pain, N = numbness, T = tingling, B = burning, C = Cramping



Please use the following symbols on the pain diagram to accurately describe your condition.

Patient Name: _____

Complaint History

Complaint 1:
When did your complaint first begin? _____ Have you ever experienced this complaint before? _____
What makes your problem better? _____
What makes your problem worse? _____
Describe the type of pain/symptom you experience? _____ _____
_____
Does your problem travel into any other part of your body? Where? _____
_____
Where exactly is the complaint area? _____
When do you notice the problem? _____
Have you lost control of any body part (arms, legs, bladder, bowel, etc..)? _____
Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? _____

Complaint 2:_____
When did your complaint first begin? _____ Have you ever experienced this complaint before? _____
What makes your problem better? _____
What makes your problem worse? _____
Describe the type of pain/symptom you experience? _____ _____
_____
Does your problem travel into any other part of your body? Where? _____
_____
Where exactly is the complaint area? _____
When do you notice the problem? _____
Have you lost control of any body part (arms, legs, bladder, bowel, etc..)? _____
Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? _____

Complaint 3:_____
When did your complaint first begin? _____ Have you ever experienced this complaint before? _____
What makes your problem better? _____
What makes your problem worse? _____
Describe the type of pain/symptom you experience? _____ _____
_____
Does your problem travel into any other part of your body? Where? _____
_____
Where exactly is the complaint area? _____
When do you notice the problem? _____
Have you lost control of any body part (arms, legs, bladder, bowel, etc..)? _____
Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? _____

Patient's Signature _____ Date _____
Guardian or Spouse's Signature _____ Date _____
Information taken by _____ Date _____

Chiropractic Physicians Center of Tupelo
Informed Consent for Chiropractic

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health is a state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.**

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name	Signature	Date

Doctor signature	Date

Minors:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Females:

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle: _____

Signature	Date

Chiropractic Physicians Center of Tupelo
398 North Eason Blvd • Tupelo, MS 38801 • (662)844-1414

Privacy Authorization for the Chiropractic Physicians Center of Tupelo

Dr. Barlow, DC and Dr. Mackey, DC and members of the practice staff may need to use your name, address, phone number and clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine or with a family member.

You can restrict the individuals to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments in an open room style, with other patients in the same room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed at your office visits. Private rooms are available for any other needed consultations.

You may inspect or request a copy, for a fee, the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time (#164.524)

This Notice is effective as of April 14, 2003. This authorization will expire seven years after the date in which you last received services from us. You may receive a copy of this form when needed.

I authorize you to use or disclose my health information in the manner described. I also acknowledge that I have read and received a copy of the Chiropractic Physicians Center of Tupelo's Privacy Policy.

Patient Signature_____ Date_____