

**Personal Information:**

Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ x \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Medical Doctor's Name: \_\_\_\_\_ Doctor's Location: \_\_\_\_\_  
Soc Sec Num: \_\_\_\_\_ How did you hear about our office: \_\_\_\_\_  
Permission to email updates concerning the practice:  yes  no    Permission to send reports to medical doctor:  yes  no

**Health Information:**

Any back pain on cough or sneeze:  yes  no    Do you drink alcohol:  yes  no    If yes, how many per day: \_\_\_\_\_  
Any bowel/bladder control problems:  yes  no    Do you smoke tobacco:  yes  no    If yes, how many per day: \_\_\_\_\_  
Women: are you currently pregnant:  yes  no    Do you exercise:  yes  no    If yes, how many days per week: \_\_\_\_\_  
Surgeries/Fractures (include dates):  none, or \_\_\_\_\_  
Auto/Sports Injuries (include dates):  none, or \_\_\_\_\_  
Describe any past treatment or tests:  none, or \_\_\_\_\_  
Allergies: \_\_\_\_\_ Medications: \_\_\_\_\_

**Do YOU now have any of the following conditions? (MARK IF YES), or:  I have none of the below conditions**

- |   |  |
|---|--|
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Stroke                                |
| <input type="checkbox"/> Arthritis or rheumatism                                    | <input type="checkbox"/> Angina                                |
| <input type="checkbox"/> Congestive heart failure                                   | <input type="checkbox"/> Cancer                                |
| <input type="checkbox"/> Deafness or trouble hearing                                | <input type="checkbox"/> Depression                            |
| <input type="checkbox"/> Sugar diabetes (diabetes mellitus) Type I                  | <input type="checkbox"/> Kidney disease                        |
| <input type="checkbox"/> Sugar diabetes (diabetes mellitus) Type II adult onset     | <input type="checkbox"/> Sciatica or chronic back problem      |
| <input type="checkbox"/> Blindness or trouble seeing, even when wearing glasses     | <input type="checkbox"/> Heart attack or myocardial infarction |
| <input type="checkbox"/> Ulcer or gastrointestinal bleeding (excluding hemorrhoids) | <input type="checkbox"/> Hypertension or high blood pressure   |
| <input type="checkbox"/> Chronic lung disease (including bronchitis or emphysema)   | <input type="checkbox"/> Other: _____                          |

**Did anyone in your FAMILY have any of the following conditions? (MARK IF YES), or:  my family had none of these**

- |   |                                  |                                 |                                      |  |                                  |                                 |                                      |
|---|----------------------------------|---------------------------------|--------------------------------------|--|----------------------------------|---------------------------------|--------------------------------------|
| <input type="checkbox"/> Stroke:              | <input type="checkbox"/> sibling | <input type="checkbox"/> parent | <input type="checkbox"/> grandparent | <input type="checkbox"/> Asthma:       | <input type="checkbox"/> sibling | <input type="checkbox"/> parent | <input type="checkbox"/> grandparent |
| <input type="checkbox"/> Cancer:              | <input type="checkbox"/> sibling | <input type="checkbox"/> parent | <input type="checkbox"/> grandparent | <input type="checkbox"/> Arthritis:    | <input type="checkbox"/> sibling | <input type="checkbox"/> parent | <input type="checkbox"/> grandparent |
| <input type="checkbox"/> Diabetes:            | <input type="checkbox"/> sibling | <input type="checkbox"/> parent | <input type="checkbox"/> grandparent | <input type="checkbox"/> Anemia:       | <input type="checkbox"/> sibling | <input type="checkbox"/> parent | <input type="checkbox"/> grandparent |
| <input type="checkbox"/> Heart Disease:       | <input type="checkbox"/> sibling | <input type="checkbox"/> parent | <input type="checkbox"/> grandparent | <input type="checkbox"/> Allergies:    | <input type="checkbox"/> sibling | <input type="checkbox"/> parent | <input type="checkbox"/> grandparent |
| <input type="checkbox"/> Kidney Disease:      | <input type="checkbox"/> sibling | <input type="checkbox"/> parent | <input type="checkbox"/> grandparent | <input type="checkbox"/> Alcoholism:   | <input type="checkbox"/> sibling | <input type="checkbox"/> parent | <input type="checkbox"/> grandparent |
| <input type="checkbox"/> High Blood Pressure: | <input type="checkbox"/> sibling | <input type="checkbox"/> parent | <input type="checkbox"/> grandparent | <input type="checkbox"/> Tuberculosis: | <input type="checkbox"/> sibling | <input type="checkbox"/> parent | <input type="checkbox"/> grandparent |

**Health Insurance Portability and Accountability Act (HIPAA) Notice:** (please sign at signature line at bottom of this page)  
By subscribing my name below, I acknowledge receipt of a copy of the HIPAA Notice, and my understanding and my agreement to its terms. The information within this chart is confidential. I understand if I request release of my records, unless specifically requested in writing otherwise, any record may be made available according to the terms and conditions of HIPAA. I authorize any health care facility to release my health records allowed under the terms and conditions of HIPAA necessary for my treatment to Paul F. Bivrell, D.C.

**Consent and Financial Awareness:** (please sign at signature line at bottom of this page)  
The undersigned hereby consent to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and all treatments are choices between risks and benefits. I understand that I have a responsibility to communicate honestly with Dr. Bivrell and to notify him of any changes in my health status. I understand I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. I hereby assign my major medical insurance benefits, including Medicare, private insurance and other health plans to Paul F. Bivrell, D.C. Any overpayment will be promptly refunded. I also authorize Paul F. Bivrell, D.C., to release any information required to secure payment according to the terms and conditions of HIPAA.

Patient | Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>PATIENT INFORMATION</b>	Name	_____	Date	_____
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