



Patient Information

Patient Name: _____
(last) (first) (middle initial)

Address: _____

City: _____ State ____ Zip _____

Cell / Home Ph: (_____) _____ Text Y/ N

Work Ph: (_____) _____

Email: _____

Best Contact: Phone Text Email

SS#: _____ DOB: _____

Sex: M or F Age: _____

Status : Single Married Widowed Divorced
 Separated Minor

Occupation: _____

Employer: _____

Spouse
Employer: _____

In Case of Emergency

Name: _____

Relationship _____

Cell / Home Ph: (_____) _____

How Did You Hear About Us?

Referral: _____

Internet: _____

Other: _____

Previous Care

What Type of Treatment have you received?

Did it Resolve the Condition: Yes No

Primary Care Physician's Name _____

Clinic Name/Number _____

I allow my health progression to be shared with my
primary care physician: Yes No

Insurance Information

Assignment and Release

I understand and agree that (regardless of whatever health or medical benefits I have), I am ultimately responsible to pay 1st Place Health, Dr. Scott Craig, as well as all employees, employers, representatives, and agents thereof, (hereinafter referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical services rendered and for any supplies, tests or medications that **have been or will be** provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payments and benefits and all legal and other health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or minor dependent) may have under my/our applicable health plan(s) or health insurance policy(ies).

This assignment includes, but not limited to, a designation that Healthcare Provider can act on my/our behalf, as our representative or ERISA representative, as to any initial claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action and/or protect benefits and/or payments that are due (or have previously paid) to Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer, or any administrator. I hereby declare that Healthcare Provider is a my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and designation remain in effect unless revoked in writing, and a photocopy is to be considered as valid and enforceable as the original.

To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need. I acknowledge receipt of a copy of the office 'Notice of Patient Privacy Policy'.

Signature of Patient, Parent, Guardian or Personal Representative

Print Name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Date

Chief Complaint

What is the main issue you are seeing the doctor for?

Is it on the (circle) Right side / Left Side / Middle / Upper / Lower / Front / Back?

How often do you have this problem?

When did you first notice the problem?

What treatments have you tried? Did they work Yes / No ?

What activities have you given up or push through due to the problem?

Additional Symptoms We May Help With Survey

Foot Pain	Right / Left	Neuropathy	Carpal Tunnel
Hand Pain	Right / Left	Fibromyalgia	Digestive / Leaky Gut
Knee Pain	Right / Left	Headaches	Weight Issues
Hip Pain	Right / Left	Dizziness	Long COVID
Shoulder Pain	Right / Left	Brain Fog	Plantar Fasciitis
Elbow Pain	Right / Left	Fatigue	Any others not mentioned
Wrist Pain	Right / Left	Sports Injuries	_____
Neck Pain	Right / Left	Constipation	_____
Low Back Pain	Right / Left	Pregnancy	_____

Family History

Previous Hospitalization or surgery:

Allergies/Medication Allergies:

Use of:

Alcohol	Never	Rare	Moderate	Daily
Tobacco	Never	Rare	Moderate	Daily
Recreational Drugs	Never	Rare	Moderate	Daily
Exposure to:	Fumes	Dust	Solvents	Noise

Hobbies and activities: Exercise Family Boating Hiking Reading
 Sports Church Groups Others:

FAMILY MEDICAL HISTORY

Mother: Age: Disease(s): Cause of Death:
 Father: Age: Disease(s): Cause of Death:
 Siblings: Age(s): Disease(s): Cause of Death:
 Children: Age(s): Disease(s): Cause of Death:

Medical History

Check all conditions that apply to you:

- | | | |
|---|--|--|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Back Trouble | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hives or Eczema | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Infectious Mono | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other Diseases |
| <input type="checkbox"/> Blood / Plasma Transfusion | <input type="checkbox"/> Kidney Disease | _____ |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Thyroid Disease | _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> AIDS or HIV | _____ |

Are you diabetic? Yes / No Type 1 or Type 2 Pre-Diabetic Diagnosis Date: _____

Last A1C: Date: Last Fasting Blood Sugar Level: Date: _____

Do you have any implantable devices? Yes / No Where: _____

Do you have a history of seizures / passing out? Yes / No Date of Last Episode: _____

History of cellulitis? Yes / No

Any current wounds, rashes, or skin infections? Yes / No Where: _____

Please list all medications you are currently taking

Name	Dosage	What condition is this for
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patients in our practice may be contacted via phone/text message to be reminded of an appointment, to obtain feedback on an experience within our office, and to provide general health reminders/information.

I consent to receiving appointment reminders and other healthcare communications from 1st Place Health:

_____ (initial) **via telephone**

_____ (initial) **via text** at my cell phone and any number forwarded or transferred to that number.

_____ (initial) **via email**

I understand that this request to receive messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

Signature: _____ Date: _____

Clinician Reviewed: _____ Date: _____

1st Place Health 40 E. Cherry St. Scottsburg, IN 47170 812-752-6202

Patient Health Information

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations, we require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. I acknowledge receipt of the "Notice of Patient Privacy Policy".

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.
3. A patient's written consent needs only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

Signature: _____ Date: _____

CONSENT

Acknowledgment of Risks, Injury & Obligations: As a client, I acknowledge that the activity I am to undertake at 1st Place Health will expose me to certain risks. I acknowledge and understand that while participating in such activity; • I may be injured, physically or mentally, or may die • Any physical conditions I may have, could be exacerbated or intensified by my participation in the activity • My personal property may be lost or damaged • Other persons participating in such activity may cause me injury or may damage my property • I may cause injury to other persons or damage their property • The conditions in which the activity is conducted may vary without warning • I may be injured or die or suffer damage to my property as a result of the negligence or breach of contract by 1st Place Health. • There may be no or inadequate facilities for treatment or transport of me if I am injured • I assume the full risk of and full responsibility for any injury, death or property damage resulting from my participation in the activity including, without limitation, any of the above situations.

Release and Indemnity: As a client, I participate in the activity at my sole risk and responsibility. I release, identify and hold harmless 1st Place Health, its servants and agents, from and against all and any actions or claims which may be made by me or on my behalf or by other parties for or in respect of or in any way related to any injury, loss, damage or death caused to me or my property whether by negligence, breach of contract or in any way whatsoever. Medical contraindications of pregnancy, cancer, medically implanted device(s), epilepsy, severe hypertension, cardiovascular disease, renal disease, immune disease(s), and blood disorders/ diseases do not apply to my current health status. I acknowledge and agree that any vehicles, and their contents, parked in any car lot or elsewhere on the premise of 1st Place Health are left at the owner's risk and 1st Place Health will accept no liability for loss, damage or theft. It is my responsibility to ensure that I correctly operate or use any facilities and/or equipment provided by 1st Place Health including the adjustment of levels or settings on the equipment. It is my duty to consult a member of staff before use, if I am in any doubt as to how to correctly operate any equipment. I also authorize the healthcare staff to perform the necessary services I may need.

Signature: _____ Date: _____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant, and the doctors and staff of 1st Place Health have my permission to perform x-ray(s). I have been advised that x-rays can be hazardous to an unborn child.

Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the release of all medical information requested by my insurance carrier, attorney, or other health care facility as needed. I also authorize 1st Place Health to obtain information from my insurance carrier, attorney, or other health care provider as needed.

Signature: _____ Date: _____

Clinician Reviewed: _____ Date: _____
1st Place Health 40 E. Cherry St. Scottsburg, IN 47170 812-752-6202