COASTAL INTEGRATIVE HEALTH

New Patient Case History/Information

Date: _____/_____/____

Patients Full Name: _____I prefer to be called: _____

Date of Birth: _____/_____/_____ Social Security #:_____ Marital Status: S M D W Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell: _____Work Number:_____

Email: _____

Occupation: _____ Hours/week: _____

Emergency Contact: _____Relationship: _____

Phone: _____

How were you referred to our office? _____

Is Today's Visit Due to a Work's Compensation Injury: Yes _____ No _____

Is Today's Visit Due to a Personal Injury or Auto Accident case: Yes _____ No _____

Primary Care Physician: _____Referring Physician(if applicable):_____

Primary Insurance Company: _____

Secondary Insurance Company (if applicable): _____

Policy Holder Name: _____Policy Holder DOB: _____ Relationship:_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the Doctors of Coastal Integrative Health, and/or In Motion Physical Therapy. I authorize the doctor(s) to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic/physical therapy care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you before signing this consent. The following person(s) have my permission to receive my personal information:

_____

_____

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Patient Name: _____

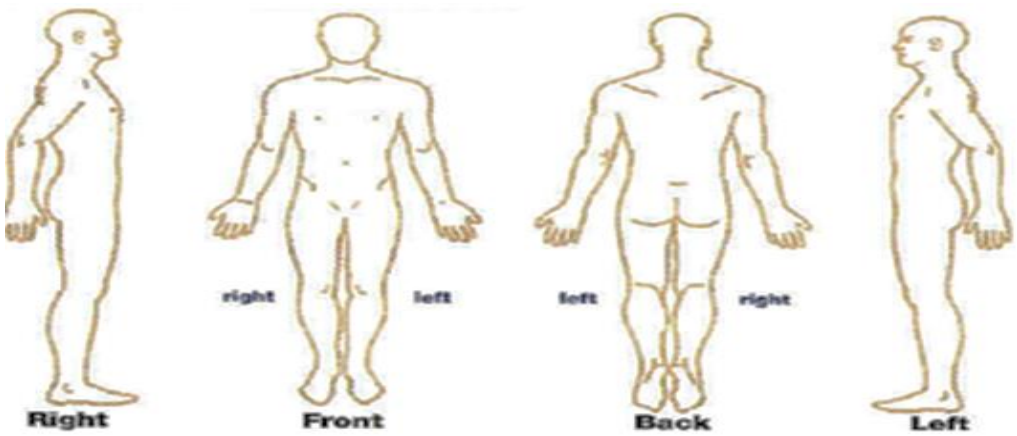
Reason for today's visit:

Emergency___ New injury___ Old injury___ Chronic Pain___ Wellness___ Physical Therapy___

Are you in pain: Yes No Rate your pain with the following scale:

Discomfort 1 2 3 4 5 6 7 8 9 10 intense

Using the body charts, please circle all affected areas:



Have you been treated by a Medical Physician for this condition? Yes____ No____

If so, where? _____

Have you ever been treated by a Chiropractor? Yes____ No____

Clinic or Dr's name: _____

Health History

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/ Stroke	**Y N** Heart surg./Pacemaker	**Y N** Heart Murmur	**Y N** Congenital Heart Defect
Y N Mitral Valve prolapsed	**Y N** Artificial Valves	**Y N** Alcohol / Drug Abuse	**Y N** Venereal Disease
Y N Hepatitis	**Y N** HIV+ /AIDS/ARC	**Y N** Shingles	**Y N** Cancer
Y N Frequent Neck Pain	**Y N** Glaucoma	**Y N** Anemia/Diabetes	**Y N** High Blood Pressure
Y N Low Blood Pressure	**Y N** Rheumatic Fever	**Y N** Severe/ Frequent Headaches	**Y N** Kidney Disease
Y N Ulcers / Colitis	**Y N** Fainting/seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Emphysema/ Asthma
Y N Tuberculosis	**Y N** Difficulty Breathing	**Y N** Chemotherapy	**Y N** Lower Back Problems
Y N Psychiatric Problems	**Y N** Arthritis	**Y N** Artificial Bones/Joints/Implants	

*Females Only: Are you or could you be pregnant? Yes____No___

Patient Name:_____

Surgeries: (Circle all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	
Hernia	Other _____		

Please list all current medications being taken:

_____
_____
_____
_____
_____

Please list all vitamins, minerals, supplements or herbs being taken:

_____
_____
_____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____	Vigorous Exercise	_____	Family Pressures
_____	Moderate Exercise	_____	Financial Pressures
_____	Alcohol Use	_____	Other Mental Stresses
_____	Drug Use	_____	Other (specify) _____
_____	Tobacco Use	_____	
_____	Caffeine	_____	
_____	High Stress Activity		

I certify the information provided is accurate to the best of my knowledge:

Name of Patient: _____

Signature of Patient/Legal Guardian: _____

Date: _____