

### Patient Information (Please print)

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
S.S. \_\_\_\_\_ Gender  Female  Male Birth date \_\_\_\_\_  
 Single  Married  Widowed  Divorced  Separated Spouse \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Person to contact in case of emergency \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Emergency contact phone number(s) \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

### Responsible Party & Insurance Information

Name of person responsible for this account \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ PolicyID# \_\_\_\_\_ Group# \_\_\_\_\_  
Subscriber/Guarantor's Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Birth date \_\_\_\_\_ S/S # \_\_\_\_\_ Contact ph: \_\_\_\_\_  
Name of employer \_\_\_\_\_ Contact ph: \_\_\_\_\_  
Do you have additional insurance?  Yes  No If YES, please complete the following:  
Insurance Co. \_\_\_\_\_ PolicyID# \_\_\_\_\_ Group# \_\_\_\_\_  
Subscriber/Guarantor's Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Birth date \_\_\_\_\_ S/S # \_\_\_\_\_ Contact ph: \_\_\_\_\_  
Name of employer \_\_\_\_\_ Contact ph: \_\_\_\_\_

### Patient Condition

**Is condition due to an accident or injury?**  Yes  No If yes please fill out additional forms.

Reason for visit \_\_\_\_\_  
When did you first notice symptoms? \_\_\_\_\_  
Is this condition getting progressively worse?  Yes  No  Unknown  
Rate the severity of pain (1 mild or discomfort to 10 severe):  
 1  2  3  4  5  6  7  8  9  10  
Type of pain:  Sharp  Throbbing  Aching  Shooting  
 Burning  Stiffness  Dull  Numbness  
 Cramps  Swelling  Tingling  Other \_\_\_\_\_  
How often do you have this pain? \_\_\_\_\_  
Is the pain constant or does come and go? \_\_\_\_\_  
Does it interfere with your:  Work  Sleep  Recreation  Daily Routine  
What is difficult to perform?  Sitting  Standing  Walking  Bending  Lying down  
 Other \_\_\_\_\_

**Health History**

What treatment have you already received?  Medication  Surgery  
 Physical therapy  Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition: \_\_\_\_\_

Check to indicate if you have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Psychiatric Care     |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Measles             | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Allergy Shots       | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Migraine/Headaches  | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Fractures        | <input type="checkbox"/> Miscarriage         | <input type="checkbox"/> Scarlet Fever        |
| <input type="checkbox"/> Anorexia            | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Goiter           | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Suicide Attempt      |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Gonorrhea        | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Gout             | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Tonsillitis          |
| <input type="checkbox"/> Bleeding Disorders  | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Breast Lump         | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tumors Growths       |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Hernia           | <input type="checkbox"/> Pinched Nerve       | <input type="checkbox"/> Typhoid Fever        |
| <input type="checkbox"/> Bulimia             | <input type="checkbox"/> Herniated Disk   | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Herpes           | <input type="checkbox"/> Polio               | <input type="checkbox"/> Vaginal Infections   |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problem    | <input type="checkbox"/> Venereal Disease     |
| <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Prosthesis          | <input type="checkbox"/> Whooping Cough       |
| <input type="checkbox"/> Chemical Dependency |   | <input type="checkbox"/> Other: _____        |   |

Dates of last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_  
 Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_  
 Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Are you pregnant?  Yes  No Nursing?  Yes  No

Injuries/Surgeries you have had:	Description:	Date:
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Please list all medications you are currently taking: \_\_\_\_\_

Please list all allergies \_\_\_\_\_

Please list all vitamins/herbs/minerals you are currently taking: \_\_\_\_\_

**Daily Habits**

Type of exercise you perform on a daily basis?  None  Moderate  Heavy

Work Activity:  Sitting  Standing  Light labor  Heavy Labor

Habits:  Smoking Packs/day \_\_\_\_\_  
 Alcohol Drinks/week \_\_\_\_\_  
 Coffee/ Caffeine Drinks Cups/day \_\_\_\_\_  
 High Stress Level Reason \_\_\_\_\_

**Authorization**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I am requesting treatment from Reservoir of Health, LLC for chiropractic adjustments and therapies. I understand that I may further request clarification about above mentioned therapies from my chiropractor. I authorize the chiropractor to release my information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Payment of co-pays for office fee is due the day of service. I understand that I will be charged a \$45 fee for any cancellation with less than 24 hours advance notice. This fee is not covered by insurance.

X \_\_\_\_\_  
Signature of Patient/ Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to patient

**Privacy Notice**

Please read the first page of our privacy notice before reading and signing this.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health relation information should be proved to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Maura C. Lyddy, D.C.

If you would like further information about our privacy policies and practices, please contact Maura C. Lyddy, D.C.

X \_\_\_\_\_  
Signature of Patient/ Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to patient