Jared M Shelton, DC,BS, CSCS

Patient Information:

Thank you for choosing our practice! Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We are happy to help.

(Please print)
Name:_____ Social Security #:_____ Date:_____
(First MI Last)
Address:_____City:_____ State:_____
ZIP_____

Sex: □ Female □ Male Birthday:_____ Email:_____
Home Phone:_____ Cell Phone: _____ Work Phone:_____
How do you prefer to be contacted? □ Phone □ Cell □ Email □ No Preference

Patient Status

□ Married □ Widowed □ Single □ Minor □ Separated □ Divorced □ Partnered
Patient Employer/School:_____
Occupation:_____
Spouse/Parent Name:_____ Employer:_____
Phone:_____
Person to contact in case of emergency:_____Phone: _____

Whom may we thank for referring you to us?_____

Responsible Party:

□ Self/Same as above (Skip following if same as above) □ Other (Please complete the following if other)
Name of person responsible for this account:_____

Insurance Information:

Primary insurance:
Do you have an insurance card? □ Yes □ No Office Use Only: (Copy of Card on file □)

Secondary Insurance: □ Yes □ No Office Use Only: (Copy of Card on file □)

Financial Responsibility

By signing this statement I agree that I have reviewed Bear River Chiropractic's Financial Policy and agree to the terms listed including payment at time of service of applicable charges, deductible payments, copayments, or fee for services not otherwise prearranged.

Authorization to Release Medical Information

I authorize Bear River Chiropractic to release/request medical information on my behalf to/from any entity to assist in my medical care per my request. This assignment will remain in effect until revoked in writing.

Private Health Information

My signature below acknowledges that I was provided the opportunity to receive/review a copy of Bear River Chiropractic's Privacy Policy Notice.

Assignment of Insurance Benefits

I directly assign my insurance benefits to the billing physician otherwise payable to me for services rendered:

Consent to Treat

I have read and understand the risks regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result. I give my consent for treatment.

Patient signature:_____ Date:_____

Bear River Chiropractic
www.bearriverchiro.com
Work Hard. Play Hard. We Have Your Back!

	Cessation
	Blood Pressure
	Temperature
	Spo2%
	Heart Rate
	Weight
	Height
	Name

Symptoms:

Problem(s)?_____
First noticed:_____ Have you ever had this problem before & when?_____

Is this condition getting □ Progressively worse over time □ Constantly the same □ A little better over time

Any activity difficult for you to perform? □ Sitting □ Standing □ Walking □Exercising □ Bending
□ Laying down □ Breathing □ Other:_____
Type of Pain (mark all that apply): □ Sharp □ Dull □ Throbbing □ Aching □ Shooting □ Burning
□ Tingling □ Cramps □ Stiffness □ Swelling □ Other: _____
Do you have numbness, tingling, weakness, or clumsiness of the arms/hand or legs/feet □ Yes □ No

Rate the severity of your pain 0-10 (0=none – 10=severe): circle one- 0 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go?_____
Have you tried any treatment for this condition before seeing us? □ Yes □ No
Treatments:_____

Past Health: (check only those that apply)
□ Lower back pain □ Neck pain □ Middle back pain □ Shoulder pain □ Aids/HIV □ Alcoholism

□ Allergy shots □ Anemia □ Arthritis □ Asthma □ Bleeding disorder □ Blood Pressure

□ Breast lump/cancer □ Cancer □ Cholesterol □ Cataracts □ Depression □ Diabetes

□ Emphysema □ Epilepsy □ Glaucoma □ Gout □ Heart Disease □ Hepatitis □ Hernia □ Kidney

□ Liver □ Migraines □ Multiple Sclerosis □ Osteoporosis □ Pace Maker □ Parkinson's disease

□ Prostate Problems □ Prosthesis □Rheumatoid arthritis □ Stroke □ Thyroid

□Tumors/Growths(other than cancer) □ Ulcers □ Other:_____

Women only:
Are you pregnant or could you be pregnant? □ Yes □ No Nursing? □ Yes □ No Birth control? □ Yes □ No
Past Surgeries and dates:_____
_____
_____

Current Medications/Supplements and reason:_____
_____
_____

Medical Allergies: _____ Flu Shot □ No □ Yes Pneumonia Shot □ No □ Yes

Do you smoke? □ No □ Yes-How much_____ Drink Alcohol? □ No □ Yes
Do you drink/take caffeine? □ No □ Yes (□ Coffee □ Soda pop □ Energy drinks □ pills □other:_____)

Do you exercise? □ No □ Yes (How much?: □ mild □ moderate □ heavy) Type:_____

I certify to the best of my knowledge the above is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I **cannot** find the health care provider negligent if I fail to deliver a full and accurate history of my health.

Signature_____ Print Name _____Date_____