POWERS (402) 504-4344
CHIROPRACTIC, P.C. 11343 Wright Circle · Omaha, NE 68144 · www.powerschiropractic.info
Wellness, Restoration, Balance Cory G. Powers, D.C.

## *CONFIDENTIAL PATIENT INFORMATION*

*Full Name: _____ Date: _____*

*Date of Birth: _____ Age: _____ Gender: _____ SSN: _____*

*Address:_____City:_____State:_____Zip:_____*

*Mobile Phone: _____ Work Phone: _____ Home Phone: _____*

*Email Address: _____*

*Who may we thank for referring you to us? _____*

*If you were not referred to us, how did you choose our office? _____*

*Spouse's Name: _____Spouse Date of Birth: _____*

*Number of Children? _____Women: Are you pregnant? Yes □ No □ If so, how many weeks? _____Due Date?_____*

*Marital Status: Married □ Single □ Widowed □ Divorced □*

*Occupation: _____ Employer: _____*

*Employer Address_____*

*Spouse's Employer: _____*

*Do you have Medicare coverage? Yes □ No □*

*In Case of Emergency Contact: _____ Phone: _____*

*Do you wish to authorize any person to request or discuss your protected health information with us? Yes □ No □*

*Name of authorized person and relationship to you: _____*

**Please describe the problem(s) that brought you to our office for care: ("1"=Minimal, "10"=Excruciating/Severe)**

1._____*Please circle your level of pain **right now**. 1 2 3 4 5 6 7 8 9 10*

*Please circle your pain **most of the time**. 1 2 3 4 5 6 7 8 9 10*

*Please circle your pain **at its best**. 1 2 3 4 5 6 7 8 9 10*

*Please circle your pain **at its worst**. 1 2 3 4 5 6 7 8 9 10*

*2._____Please circle your level of pain **right now**. 1 2 3 4 5 6 7 8 9 10*

*Please circle your pain **most of the time**. 1 2 3 4 5 6 7 8 9 10*

*Please circle your pain **at its best**. 1 2 3 4 5 6 7 8 9 10*

*Please circle your pain **at its worst**. 1 2 3 4 5 6 7 8 9 10*

How long have you been experiencing these problems? _____

Getting Better □ Getting Worse □ Not Changing □

What other health care providers have you consulted for help? (Check all that apply)

*Medical Doctor □ Specialist MD (Orthopedist, Neurologist, Surgeon, etc.) □ Doctor of Chiropractic □*

*Physical Therapist □ Massage Therapist □ Acupuncturist□ Other □:_____*

Are you taking pain medications, anti-inflammatory medication, or muscle relaxants for this condition? Yes□ *No*□

*Which type, how much, and how often?* _____

This problem is affecting my: *Work* □ *Relationships* □ *Sleep* □ *Daily Routines* □ *Exercise* □ *Recreation* □

Do you currently use tobacco of any kind? *Yes* □ *Former Smoker* □ *Never a Smoker* □

Are you taking any other medications at this time? Please list them:

_____

_____

Stress can have a profound effect on your health and well-being. Please rate your present level of stress on a scale of 1-10, "1" being very little/no stress and "10" being very intense/debilitating stress:

*Stress at home:* _____ *Stress at work:* _____ *Stress "in general":* _____

Please mark the following conditions you may have had or have now (- have had + have now):

| | | | | | |
|---|---|---|---|---|---|
| □ *Alcoholism* | □ *Allergy* | □ *Anemia* | □ *Atherosclerosis* | □ *Arthritis* | □ *Asthma* |
| □ *Anxiety* | □ *Back Pain* | □ *Blood Pressure* | □ *Cancer* | □ *COVID-19* | □ *Concussion* |
| □ *Depression* | □ *Diabetes* | □ *Digestion Issues* | □ *Eczema* | □ *Emphysema* | □ *Epilepsy* |
| □ *Fibromyalgia* | □ *Gall Bladder* | □ *Gout* | □ *Headaches* | □ *Heart Attack* | □ *Heart Disease* |
| □ *HIV* | □ *Hormone Issues* | □ *Low Blood Sugar* | □ *Menstrual Cramps* | □ *Migraines* | □ *Miscarriage* |
| □ *M.S.* | □*Mumps* | □ *Neuritis* | □ *Pleurisy* | □ *Pneumonia* | □ *Polio* |
| □ *Ringing in ears* | □*SinusProblems* | □ *Spine Fracture* | □ *Stroke* | □*Substance Abuse* | □ *Thyroid* |
| □ *Tuberculosis* | □ *Ulcers* | □ *Whooping Cough* | | | |

Other conditions not named above:_____

I hereby authorize Powers Chiropractic, PC to release any information necessary to process insurance claims. I assign all benefits payable directly to Cory G. Powers, D.C. Health insurance may not pay for services considered maintenance, supportive, or deemed "not medically necessary" even though you may want the care, need the care to prevent worsening of your condition, have symptoms that respond to chiropractic care, or have a certain number of "visits" in your policy. I agree that I am financially responsible for all non-covered services.

**X**_____

*Patient or Parent/Legal Guardian Signature* *Date*

I hereby authorize Cory G. Powers, D.C. to treat my condition as he deems appropriate through the use of chiropractic adjustments and any other treatment modalities within the scope of his license. I understand and accept any risks associated with this type of treatment. I understand that Dr. Powers is not responsible for treatment of previously diagnosed medical conditions that are outside his scope of practice or for treatment for conditions that I have not disclosed.

**X**_____

*Patient or Parent/Legal Guardian Signature* *Date*

I acknowledge that the Privacy Notice (HIPAA) has been made available to me.

**X**_____

*Patient or Parent/Legal Guardian Signature* *Date*