

**SCHULZE FAMILY CHIROPRACTIC**  
2900 Calloway Dr., Ste 404, Bakersfield, CA 93312  
Phone: 661-204-6137 Fax: 661-399-6477

**OFFICE USE ONLY**  
Date \_\_\_\_\_  
Acct# \_\_\_\_\_  
X-ray # \_\_\_\_\_

### Patient Entrance Form

Please Note: Our new extensive entrance form is necessary for compliance with the Health Care Financing Administration and the National Committee for Quality Assurance's new standards. Please fill it out completely.

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_  
Age \_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M / F No. Children \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_  
Marital Status:  Single  Married  Widowed  Separated  Divorced  Student  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_  
Spouse Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Relationship \_\_\_\_\_  
Patient's Primary Care Physician (PCP) \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Date of Last Physical Exam \_\_\_\_\_ Referred by: \_\_\_\_\_

Please describe your current problem \_\_\_\_\_

Is your current problem the result of: Auto Accident?  Yes  No Work Accident?  Yes  No Slip & Fall?  Yes  No

How did your problem begin \_\_\_\_\_

Date Problem began \_\_\_\_\_ Other doctors seen for this condition \_\_\_\_\_

List other treatments or tests you've had for this condition \_\_\_\_\_

Have you been treated for any other health condition by a physician in the last year?  Yes  No If yes, please explain:

How often are your symptoms present?  Constantly  Frequently  Occasionally  Intermittently

Describe your current pain/symptoms:  Sharp/Stabbing  Burning  Throbbing  Shooting  Tingling  Gripping  
 Dull  Numbness  Soreness  Aches  Weakness  Other \_\_\_\_\_

Since it began, is your problem:  Improving  Getting Worse  No Change

What makes the problem better?  Nothing  Lying Down  Standing  Walking  Sitting  Movement  
 Exercise  Inactivity/Rest  Other \_\_\_\_\_

What makes the problem worse?  Nothing  Lying Down  Standing  Walking  Sitting  Movement  
 Exercise  Inactivity/Rest  Other \_\_\_\_\_

Can you perform your daily home activities:  Yes  Only with help  Not at all

Do you exercise?  Yes, almost daily  Yes, occasionally  Not at all

Describe your job requirements:  Mainly Sitting  Light Labor  Heavy Labor

Can you perform your daily work activities:  Yes, all activities  Only some  Not at all

Describe your stress level:  None to mild  Moderate  High

**SCHULZE FAMILY CHIROPRACTIC**  
**Patient Health Questionnaire**

Patient Name \_\_\_\_\_

Acct# \_\_\_\_\_

Please check all that apply. Knowledge of these conditions may influence the type of treatment/therapy you receive.

- |                                              |                                                     |                                                                  |
|----------------------------------------------|-----------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Angina              | <input type="checkbox"/> Heartburn/Indigestion      | <input type="checkbox"/> Rheumatic Fever                         |
| <input type="checkbox"/> Anorexia            | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Pregnancies                             |
| <input type="checkbox"/> Aortic Aneurysm     | <input type="checkbox"/> Herniated Disk             | <input type="checkbox"/> Scoliosis                               |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Stroke                                  |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Jaw Pain                   | <input type="checkbox"/> Swelling, Stiffness of Joints           |
| <input type="checkbox"/> Bladder Infection   | <input type="checkbox"/> Liver/Gallbladder Problems | <input type="checkbox"/> Tinnitus (Ear Noises)                   |
| <input type="checkbox"/> Blood Disorder      | <input type="checkbox"/> Kidney Disorders           | <input type="checkbox"/> Tuberculosis                            |
| <input type="checkbox"/> Breast Lump         | <input type="checkbox"/> Loss of Bladder Control    | <input type="checkbox"/> Ulcer                                   |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Nervousness                | <input type="checkbox"/> Vision Disturbances                     |
| <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Pacemaker                  | <input type="checkbox"/> Venereal Disease                        |
| <input type="checkbox"/> Chronic Cough       | <input type="checkbox"/> Pain - Neck                | <input type="checkbox"/> Other _____                             |
| <input type="checkbox"/> Chronic Sinusitis   | <input type="checkbox"/> Pain - Mid Back            |                                                                  |
| <input type="checkbox"/> Colitis             | <input type="checkbox"/> Pain - Low Back            | Height: _____ feet _____ inches                                  |
| <input type="checkbox"/> Convulsions         | <input type="checkbox"/> Pain - Arm/Elbow           |                                                                  |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Pain - Hand                | Weight: _____ pounds                                             |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Pain - Wrist               |                                                                  |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Pain - Shoulder            |                                                                  |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Pain - Ankle or Foot       |                                                                  |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Pain - Leg                 | <b><u>For all patients over 13 yrs. old:</u></b>                 |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Pain - Knee                | <input type="checkbox"/> Smoking - Packs/Day _____               |
| <input type="checkbox"/> Fainting            | <input type="checkbox"/> PMS                        | <input type="checkbox"/> Alcohol - Drinks/Week _____             |
| <input type="checkbox"/> Headache            | <input type="checkbox"/> Prostate Problems          | <input type="checkbox"/> Coffee/Caffeine Drinks - Cups/Day _____ |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Rapid Heartbeat            | <input type="checkbox"/> Alcohol Dependence                      |
|                                              |                                                     | <input type="checkbox"/> Drug Dependence                         |

Please list all allergies including allergies to medications \_\_\_\_\_

List all medications you are presently taking (including vitamins & supplements)

List any surgeries, fractures, serious illnesses or hospitalizations \_\_\_\_\_

Do you have a Living Will or Advance Directive?     Yes     No

In an emergency would you want CPR?             Yes     No

In an emergency would you want life support?     Yes     No

**Family Health History:**

If a family member has had any of the following, please mark the appropriate box:

- |                                     |                                   |                                         |                                                |                                               |
|-------------------------------------|-----------------------------------|-----------------------------------------|------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Cancer     | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Chronic Headaches    |
| <input type="checkbox"/> Epilepsy   | <input type="checkbox"/> Lupus    | <input type="checkbox"/> Lung Problems  | <input type="checkbox"/> Chronic Back Problems | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Alcoholism | Other _____                       |                                         |                                                |                                               |

I certify that all the above personal health information, on pages one and two, is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition in the future.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**SCHULZE FAMILY CHIROPRACTIC**  
**Patient Insurance Information**

Patient Name \_\_\_\_\_

Acct# \_\_\_\_\_

**Please Note: We need to copy your insurance identification card for your file.**

**A. Subscriber Information: (Please complete A & B, if other than patient or lives at different address)**

Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Subscriber's Social Security # \_\_\_\_\_

Employer Name \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_ Ins Co. Phone (\_\_\_\_) \_\_\_\_\_

Insured's ID # \_\_\_\_\_ Group # \_\_\_\_\_

Is patient covered under any other insurance?  Yes  No If yes, please complete the following:

**B. Second Insurance:**

Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Subscriber's Social Security # \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_ Ins Co. Phone (\_\_\_\_) \_\_\_\_\_

Insured's ID # \_\_\_\_\_ Group # \_\_\_\_\_

**INSURANCE ASSIGNMENT, RELEASE OF INFORMATION, AND AUTHORIZATION**

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Schulze all insurance benefits, if any, otherwise payable to me for the services rendered. If enrolled with an HMO and without the appropriate referral or authorization from my Primary Care Physician, I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Dr. Schulze to verify healthcare benefits with my insurance company; to release all information necessary to secure the payment of benefits and to authorize the use of this signature on all insurance submissions.

A copy of this document shall be considered as valid as the original.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**OPEN TREATMENT ROOM NOTICE**

I am aware of and in acceptance of receiving chiropractic services in an Open Treatment Environment. All personal information will be discussed in a private room, however. This is designed to reduce patient time spent in office and increase the efficiency of the office. A private treatment room is available on a limited basis if requested. This room is for occasional use only and not meant to be used for every treatment.

Date: \_\_\_\_\_ Name of Patient (print) \_\_\_\_\_

Signature of Patient/Personal Representative \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE  
OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**

I acknowledge that I have received Schulze Family Chiropractic's Notice of Privacy Practices for protected health information. (Please see Privacy Notice posted on waiting room wall.)

Date: \_\_\_\_\_ Name of Patient (print) \_\_\_\_\_

Signature of Patient/Personal Representative \_\_\_\_\_

**PATIENT COMMUNICATION AUTHORIZATION**

Dr. Schulze and members of his staff may need to contact you with appointment reminders, or other health related information. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with the person who answers the phone. This contact could also be made through the mail on a postcard, and if you have referred someone to our office we need your authorization to use your name (First Name and Last Initial) on our Honor Roll Board in the office waiting room. By signing this form, you are giving us authorization to contact you with these reminders and information and to use your name (First Name and Last Initial) on our Honor Roll Board in the waiting room.

PLEASE REVIEW AND ASK ANY QUESTIONS BEFORE SIGNING.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**DISCLOSURE OF PERSONAL HEALTH INFORMATION**

Please know that we are very concerned with protecting the privacy of your personal health information. While the law requires us to notify you about this disclosure, please understand that we have, and always will, respect the privacy of your health information. However, please be advised that it may be necessary for us to disclose your health information to another health care provider if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. I have read the above privacy pledge and agree to its terms.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_