618 Coburn Avenue
Worland, WY 82401

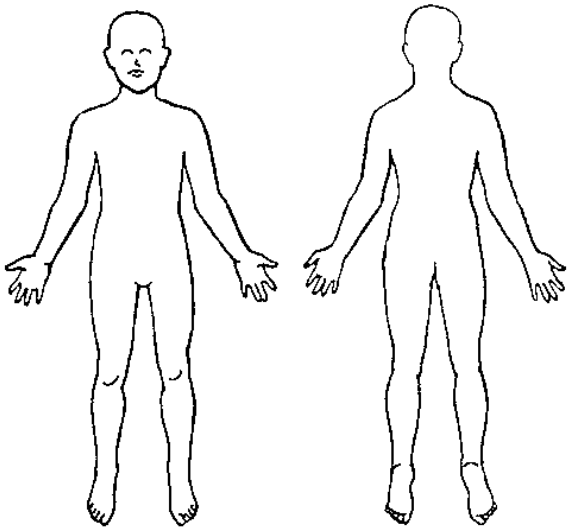
CLOUD PEAK CHIROPRACTIC & WELLNESS

Phone/Text (307) 347-3500
Fax (307) 347-4893

PATIENT INFORMATION FORM

Full Name _____I like to be called_____ Date _____
Birthdate _____ Age _____ Gender _____
Mailing Address _____ Home Phone_____
City/State/Zip _____ Cell Phone_____
Email _____ Work Phone_____
Occupation _____ Employer _____
Physical work duties _____
Marital Status: □ Single □ Married □ Divorced □ Widowed
Spouse Name _____Spouse Birthdate _____
Spouse Occupation _____ Spouse Employer _____
Person to contact in case of emergency _____Phone:_____
Whom may we thank for referring you? _____
What is the reason for your visit? _____
_____

PLEASE MARK WHERE YOU HAVE PAIN:



PLEASE MARK SYMPTOMS YOU HAVE:

□ Headaches
□ Neck Pain
□ Back Pain
□ Sleeping Problems
□ Irritability
□ Chest Pain
□ Knee Pain
□ Pins & Needles in Arms
□ Pins & Needles in Legs
□ Numbness in Toes
□ Numbness in Fingers
□ Dizziness
□ Blurred Vision
□ Loss of Balance
□ Ears Ringing
□ Loss of Concentration
□ Depression

Any other symptoms: _____
_____
_____
_____
_____
_____
_____

List your primary doctor and any other doctors seen recently: _____
_____
Have you had previous chiropractic care? _____
List any surgeries you have had: _____
_____
List any accidents/injuries/broken bones: _____
_____
List any diseases you have had (cancer, diabetes, etc): _____
_____
List all medications and vitamins you are currently or have recently taken: _____
_____

Cloud Peak Chiropractic & Wellness ● 618 Coburn Ave, Worland, WY 82401 ● 307-347-3500

Patient Name: _____ **Date:** _____

PLEASE CHECK ALL OF THE BOXES THAT APPLY TO YOU

GENERAL

PAST/PRESENT

□ □ Allergy
□ □ Chills
□ □ Convulsions
□ □ Fainting
□ □ Fatigue
□ □ Fever
□ □ Headache
□ □ Loss of Sleep
□ □ Significant weight loss
□ □ Nervousness
□ □ Depression
□ □ Nerve pain
□ □ Sweats, day or night
□ □ Tremors

EYES, EARS, NOSE & THROAT

□ □ Asthma
□ □ Crossed eyes
□ □ Deafness
□ □ Earache
□ □ Ear discharge
□ □ Ear noises
□ □ Enlarged glands
□ □ Enlarged thyroid
□ □ Eye pain
□ □ Failing vision
□ □ Farsightedness
□ □ Gum Trouble
□ □ Hay fever
□ □ Hoarseness
□ □ Nasal obstruction
□ □ Nearsightedness
□ □ Sinus infection
□ □ Sore throat
□ □ Tonsillitis

CARDIOVASCULAR

PAST/PRESENT

□ □ Hardening of arteries
□ □ High blood pressure
□ □ Low blood pressure
□ □ Heart disease
□ □ Pain over heart
□ □ Poor circulation
□ □ Rapid heartbeat
□ □ Slow heartbeat
□ □ Swelling of ankles

GASTROINTESTINAL

□ □ Colitis
□ □ Colon trouble
□ □ Constipation
□ □ Diarrhea
□ □ Difficult digestion
□ □ Swollen abdomen
□ □ Excessive hunger
□ □ Gall bladder trouble
□ □ Hemorrhoids
□ □ Jaundice
□ □ Liver trouble
□ □ Hepatitis
□ □ Nausea
□ □ Pain over stomach
□ □ Poor appetite
□ □ Vomiting
□ □ Vomiting of blood

MUSCLE & JOINT

□ □ Arthritis
□ □ Bursitis
□ □ Hernia
□ □ Spinal curvature
□ □ Swollen joints

GENITOURINARY

PAST/PRESENT

□ □ Bed wetting
□ □ Blood in urine
□ □ Frequent urination
□ □ Loss of bladder control
□ □ Kidney infection/stones
□ □ Painful urination
□ □ Prostate trouble
□ □ Pus in urine

RESPIRATORY

□ □ Chest pain
□ □ Chronic cough
□ □ Difficult breathing
□ □ Spitting up blood
□ □ Spitting up phlegm
□ □ Wheezing
□ □ Smoker

SKIN

□ □ Boils
□ □ Bruise easily
□ □ Dryness
□ □ Hives
□ □ Itching
□ □ Skin rash

OTHER

PAST/PRESENT

□ □ Alcoholism
□ □ Anemia
□ □ Appendicitis
□ □ Arteriosclerosis
□ □ Cancer
□ □ Diabetes
□ □ Diphtheria
□ □ Eczema
□ □ Epilepsy
□ □ Cold sores
□ □ Goiter
□ □ Gout
□ □ HIV positive
□ □ Malaria
□ □ Measles
□ □ Multiple sclerosis
□ □ Mumps
□ □ Pleurisy
□ □ Pneumonia
□ □ Polio
□ □ Rheumatic fever
□ □ Scarlet fever
□ □ Stroke
□ □ Tuberculosis
□ □ Typhoid fever
□ □ Ulcers
□ □ Venereal Disease
□ □ Whooping cough

Cloud Peak Chiropractic & Wellness ● 618 Coburn Avenue, Worland, WY 82401 ● (307) 347-3500

Patient Name: _____ **Date:** _____

Family Medical History: Check anything that applies to your children, siblings, parents, or grandparents:

- □ Allergy/Asthma/Eczema
- □ Cancer
- □ Diabetes
- □ Heart Problems
- □ High Blood Pressure
- □ Osteoporosis
- □ Autoimmune Disease
- □ Kidney Disease
- □ Liver Disease
- □ Mental Illness
- □ Scoliosis

Life Choices:	Daily	Weekly	Occasionally	Never
Alcohol	□	□	□	□
Drug	□	□	□	□
Tobacco	□	□	□	□
Caffeine	□	□	□	□
Diet Food Products	□	□	□	□
Soft Drinks	□	□	□	□
Energy Products/Stimulants	□	□	□	□
Preprocessed/Packaged Foods	□	□	□	□
High Stress Level	□	□	□	□
Water	□	□	□	□
Fresh/Homemade Foods	□	□	□	□
Exercise	□	□	□	□

For Women Only	Yes	No
Are you pregnant, or have you had any signs of pregnancy?	□	□
Are you planning to get pregnant in the next 12 months?	□	□
Are you breastfeeding?	□	□
Do you experience painful or very heavy periods?	□	□
Do you have irregular cycles?	□	□
Do you have hot flashes or night sweats?	□	□
Do you have breast implants?	□	□

By signing below, I authorize Cloud Peak Chiropractic & Wellness, to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Cloud Peak Chiropractic, P.C. and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

_____ _____

Signature Date

Cloud Peak Chiropractic & Wellness ● 618 Coburn Avenue, Worland, WY 82401 ● (307) 347-3500

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Cloud Peak Chiropractic & Wellness.

I understand that the Notice describes the uses and disclosures of my protected health information by Cloud Peak Chiropractic, P.C. and informs me of my rights with respect to my protected health information.

Patient's Signature or that of Legal Representative	*Printed Name of Patient or that of Legal Representative*
Today's Date	*If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

Employee Name	*Today's Date*