

**Reservoir Chiropractic, Inc.**

**This is a summary of the following pages of our Privacy Notice. Please read this and following instructions. Feel free to take the Privacy Notice home with you.**

Here is how we protect your personal details:

- 1. We will make every effort to protect your personal information. In signing below, I acknowledge I have received a Privacy Notice from Reservoir Chiropractic, which is also displayed on bulletin board:

\_\_\_\_\_ Date: \_\_\_\_\_  
 Patient Signature

- 2. We will never profit by selling your name, or using it in any way inappropriately.
- 3. We would like to send you information occasionally in the mail or on email. This will be approximately one to two times a month,, and any other special notices re: office happenings. You may opt out of this now by stating it here. Otherwise, we will assume you authorize us to communicate with you.  
 I wish to opt out of any mail contact, including email: Please sign here:

\_\_\_\_\_

\*\* I must inform you that if you sign here, you will receive nothing from our office in the mail. We cannot pick and choose which mail you get and which you don't, due to restrictions in our office software.

- 4. Signing this is voluntary, and if you do not, you will still receive the best health care possible by our staff. You may revoke the authorization at any time in writing to Dr. Joanie Winstead. You may request a copy of this signed form at any time.

I understand this form was completely filled in as I wanted it prior to signing. All my questions were answered to my satisfaction and I understand this form and all of its contents. I received a copy of the office's privacy notice.

**\*If coverage cannot be verified on the date of service payment in full may be required. Also a \$20.00 Non-Cancellation Fee will be charged if you miss an appointment or do not cancel 12 hours prior to appointment.**

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that Reservoir Chiropractic is filing my insurance as a courtesy; and insurance is no guarantee of payment, as stated by the insurance companies when we check benefits. All charges due must be paid at the time of service unless payment arrangements are made. **I understand that my insurance company may not cover fully (or at all) my bills for services provided, and that I will be responsible for payment of all charges. In the event Reservoir Chiropractic refers my account to an attorney to collect an unpaid balance, I agree to pay reasonable attorney's fees incurred in the collection of the unpaid balance.** Reservoir Chiropractic will do our best to keep track, but is NOT responsible for counting the allowable NUMBER of VISITS or MAXIMUM DOLLAR benefits per calendar year. I understand this is shown on the EOB (Explanation of Benefits) that I receive from my insurance company after each visit.

\*To the best of my knowledge, the above information 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 certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign  
 Name of Insurance Company

directly to Reservoir Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize Dr. Joanie Winstead, and all associates, and assistants to render Chiropractic services as they deem necessary.

Patient Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_  
 (or legal Guardian, parent, attorney)

Print Name: \_\_\_\_\_

Office Staff Witness: \_\_\_\_\_ Patient's Clinic I.D. \_\_\_\_\_

**Reservoir Chiropractic**  
**1090 Lake Village Circle**  
**Brandon MS 39047**  
**601-919-8800 Fax 601-919-8808**

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

SSN# \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: F M

Marital Status:  Married  Divorced  Widowed  Single Number of children? \_\_\_\_\_

**CURRENT ADDRESS:**

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_

Primary Contact:  Home  Cell  Work

Email \_\_\_\_\_

**OTHER ADDRESS FOR RESIDENCE OR BILLING PURPOSES (e.g., parents, guardian, attorney):**

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Spouse's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse's Occupation \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Spouse's Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ Contact Phone (\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Outside of Home: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

Are there any person's you wish to give us permission to share your health information with? YES NO Initials: \_\_\_\_\_

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

I was referred to this office by: \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient I.D. \_\_\_\_\_

# Symptoms

Major Complaint: \_\_\_\_\_

Start date of symptoms? \_\_\_\_\_ Are symptoms/condition getting worse? Yes No

What aggravates it? \_\_\_\_\_ What relieves it? \_\_\_\_\_

Rate the severity of pain (0-none to 10-severe) : AREA 1: \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

AREA 2: \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

OTHER: \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? \_\_\_\_\_

What activities are difficult? Sitting Standing Lying Down Bending Walking Other \_\_\_\_\_

Description of the pain: Sharp Dull Aching Burning Shooting Throbbing Numbness Tingling

Stiffness Cramping Swelling Other \_\_\_\_\_

Have you ever had the same or similar condition/symptoms before? Yes No If yes, when? \_\_\_\_\_

Have you already received other treatment for your current condition? \_\_\_\_\_

Please list any other healthcare providers that you are currently under their care:

Provider Name \_\_\_\_\_ Date of last visit \_\_\_\_/\_\_\_\_/\_\_\_\_

Provider Name \_\_\_\_\_ Date of last visit \_\_\_\_/\_\_\_\_/\_\_\_\_

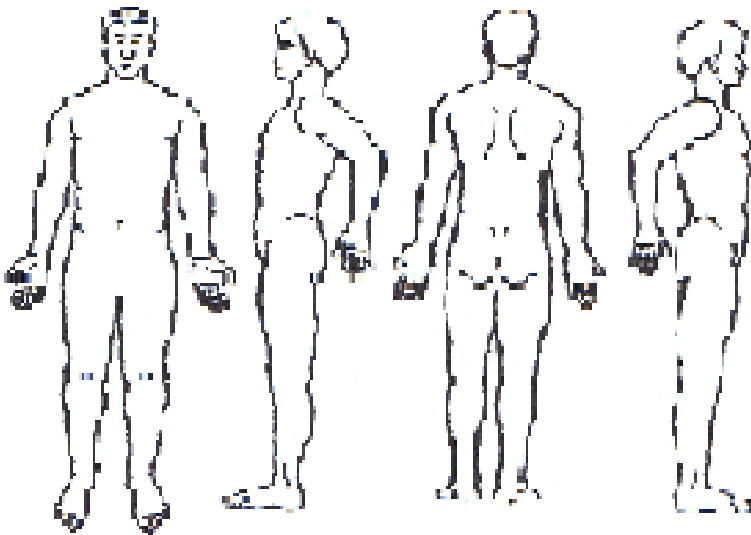
Provider Name \_\_\_\_\_ Date of last visit \_\_\_\_/\_\_\_\_/\_\_\_\_

## Body Chart

Shade your symptom area. Place an "S" for sharp pain, a "T" for tingling, a "N" for numbness and a "D" for dull pain:

What desired activities are you unable to do because of your condition or pain?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## Daily Habits

Do you exercise regularly? Yes No Describe? \_\_\_\_\_

Do you smoke or use tobacco products? Yes No How much per day? \_\_\_\_\_

How much alcohol do you consume on a weekly basis? \_\_\_\_\_

How much coffee, tea, or other caffeinated beverages do you consume per day? \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient I.D. \_\_\_\_\_

**Health and Medical History**-Circle all the present conditions, and underline the past conditions. List approximate date condition began.

Acid Reflux	Constipation	Headache	Migraines	Low Blood Pressure
AIDS/HIV	Depression	Heart Disease	Memory Loss	High Cholesterol
Allergies	Diabetes	Hepatitis	Miscarriage	Psychiatric care
Anemia	Diarrhea	Herniated Disc	Mononucleosis	Rheumatoid Arthritis
Anorexia	Difficulty Sleeping	Herpes	Multiple Sclerosis	Stroke
Appendicitis	Dizziness	High Blood Pressure	Muscle Weakness	Seizures
Asthma	Emphysema	Insomnia	Mumps	Shortness of Breath
Bloating	Epilepsy	Irritability	Osteoporosis	Nausea
Bronchitis	Fainting	Kidney Disease	Osteopenia	Vertigo
Bulimia	Fatigue	Liver Disease	Pacemaker	Nervousness/Anxiety
Cancer	Fever	Light Sensitivity	Indigestion	Suicide Attempt
Cataracts	Fractures	Loss of Smell	Pneumonia	Scoliosis
Chicken Pox	Glaucoma	Loss of Libido	Parkinson's	Thyroid Disorder
Cold Sweats	Goiter	Low Energy	Polio	Tonsillitis
Cold Feet or Hands	Gonorrhea	Measles	Prostate Disorder	Tuberculosis
TMJ Problems	Ulcers	Whooping Cough	Vaginal Infection	Prosthesis

Other \_\_\_\_\_

**Women only:** Are you pregnant? No Yes  
 Number of weeks? \_\_\_\_\_  
 Are you taking birth control pills? No Yes

**If Pregnant:** Date of Last Menstrual Period: \_\_\_\_\_  
 Nursing? No Yes

List Family history of illnesses known:

- Mother:
- Father:
- Grandparents:
- Siblings:
- Aunts/Uncles:

List any surgeries or procedures which you have had:

\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

List any allergies you have: \_\_\_\_\_

List any medications or nutritional supplements you are currently taking: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient I.D. \_\_\_\_\_