CHIROPRACTIC WELLNESS

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PATIENT FORM

Patient Data **Date** ____

Title: (Check one) ☐ Mr. ☐ Mrs. ☐Ms. ☐ Miss ☐ Dr. ☐ Other _____

First Name _____ **Middle Initial** ____ **Last Name** _____

I prefer to be called by_____

Address Line _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____) _____-_____ **Work Phone** (_____) _____-_____

Cell Phone (_____) _____-_____ **Email** _____

Date of Birth _____/_____/_____ **Sex:** ☐ Male ☐ Female

Social Security Number: _____-_____-_____ **Marital Status:** ☐ Single ☐ Married ☐ Other

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other_____

Emergency Contact_____

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (_____) _____-_____ **Cell Phone** (_____) _____-_____

How did you hear about our office? _____

Patient Name_____**Date**_____

Medical Conditions: (Check all that apply to you)
□ Arthritis □ Cancer □ Diabetes □ Heart Disease
□ Hypertension □ Psychiatric Illness □ Skin Disorder □ Stroke
□ Other _____

Surgeries: (Check all that apply to you)
□ Appendectomy □ Cardiovascular procedure □Cervical spine□ Hysterectomy
□ Joint Replacement □ Prostate □ Lumbar spine□ Gall Bladder
□ Brain □ Shoulder □ Thoracic spine □ Knee
□ Carpal Tunnel □ Gastro-intestinal □ Uro-genital □ Hernia
□ Other _____

Allergies: (List any allergies)

Social History: (Check all that apply to you)
Caffeine use: □ occasional □ often □ never
Drink Alcohol: □ occasional □ often □ never
Exercise: □ occasional □ often □ never
Tobacco Use: □ occasional □ often □ never
Sleep: Hours per night= _____
Stress Level: High Moderate Low None

Family History: (Check all that apply)
Arthritis: □ Parent □ Sibling
Cancer: □ Parent □ Sibling
Diabetes: □ Parent □ Sibling
Heart Disease □ Parent □ Sibling
Hypertension □ Parent □ Sibling
Stroke □ Parent □ Sibling
Thyroid □ Parent □ Sibling
Other _____

Patient Name_____ **Date**_____

Review of Systems – (Check if you have had trouble with any of the following within the last 3 months)

General:
___ Weight change
___ Fever
___ Chills
___ Night Sweats
___ Weakness
___ Fatigue

Eyes:
___ Vision
___ Pain
___ Discharge

Ears:
___ Hearing
___ Ringing
___ Pain
___ Discharge

Nose:
___ Pain
___ Bleeding
___ Taste

Mouth/Throat:
___ Sores
___ Bleeding
___ Taste

Skin:
___ Rash
___ Itching
___ Hair Changes
___ Nail Changes

Neurologic:
___ Headache
___ Dizziness
___ Fainting
___ Convulsions

G-I:
___ Appetite
___ Abdominal Pain
___ Vomiting
___ Diarrhea
___ Constipation

G-U:
___ Frequent Urination
___ Painful Urination
___ Incontinence

Cardio:
___ Murmur
___ Chest Pain
___ Palpitations
___ Difficulty Breathing
___ Cough
___ Wheezing
___ Blue Extremities
___ Swollen Extremities

Breasts:
___ Mass
___ Pain
___ Discharge
___ Self-exam

Psychologic:
___ Anxiety
___ Depression
___ Moods
___ Memory

Musculoskeletal
___ Neck
___ Upper Extremities
___ Upper Back
___ Lower Extremities
___ Lower Back

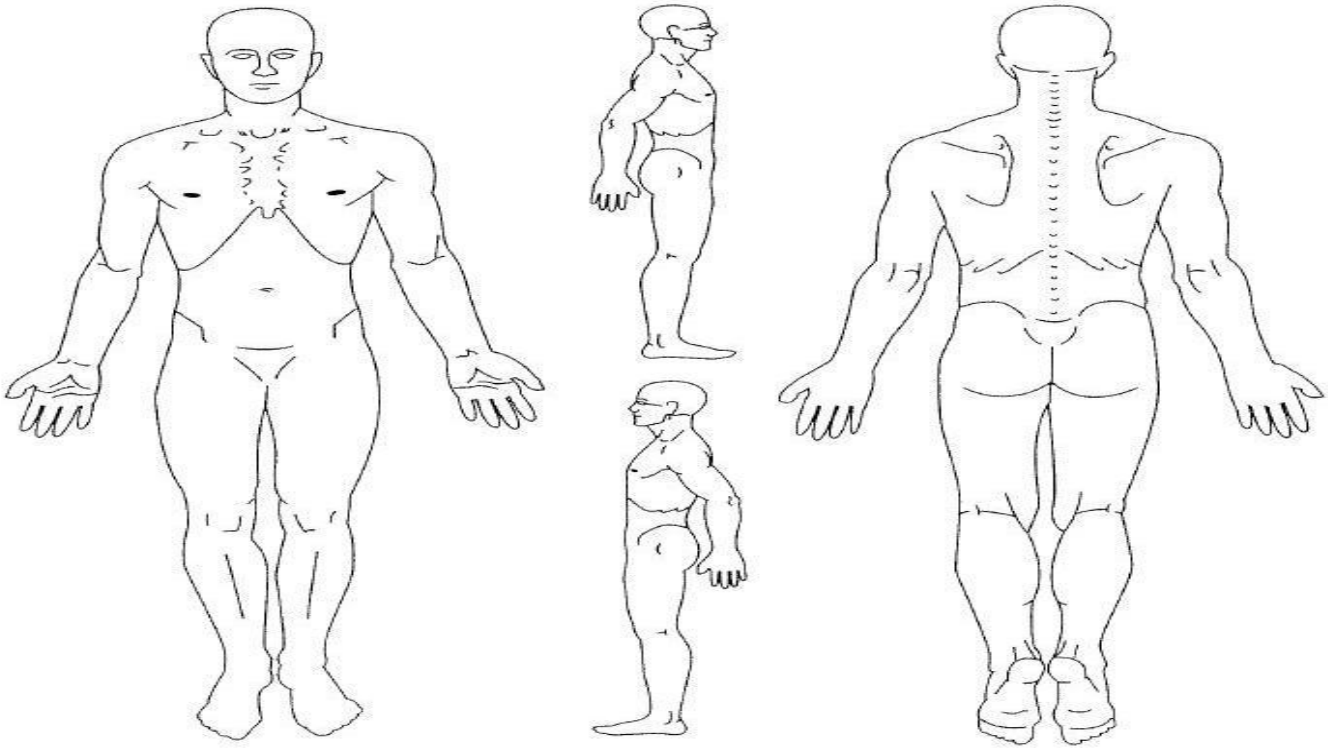
Additional Info:

Please list **ALL** current medications and/or supplements being taken:
_____
_____
_____

Patient Name_____Date_____

Are you pregnant? Yes_____ No _____N/A_____

By using the key below, indicate on the body diagram where you are experiencing pain:



On average rating from 0-10, how much pain are you experiencing? 0 = no pain and 10 = the worst pain imaginable?

Please circle: 0 1 2 3 4 5 6 7 8 9 10

Describe your symptoms in order of severity, with worse symptom being #1: _____
_____

Are your symptoms a result of: □ Motor Vehicle Accident □Work related Accident □ Other_____

How are your symptoms changing?
□ Getting better □ Not changing □ Getting worse

Patient Name **Date**

Activities of Daily Living

Please circle if you have pain or difficulty performing the following:

Bending Carrying Groceries Change Posn–Sit-Stand Climb Stairs
Driving
Extended Computer Use Feeding Household Chores Kneeling
Lift Children
Lifting Pet Care Reading (Concentration) Self Care–Bathing
Self Care–Dressing
Sexual Activities Sleep Static Sitting Static Standing
Walking
Yard Work Other_____

What type of treatment are you looking for?

___ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem

___ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem

___ I am looking to take care of my problem and then go on to "achieve optimal health and wellness"

Patient Name_____Date_____

Payment/Insurance Information:

Who is responsible for your bill? □ Self □ Health Insurance □ Spouse □ Worker's Comp
□ Auto Insur. □ Medicare

NOTE: The patient is responsible for insurance deductibles, co-pays and co-insurance.

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / ____ / _____ Primary Care Physician _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? □Yes □No Date: ____/____/____ Time: _____am / pm

If Work is responsible, Please fill out the following:

Employer Data_____

Name _____
Your Occupation _____ Your Job Description _____
Address _____
City _____ State _____ Zip Code _____

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____
Date_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____
Date_____