The Spinal Decompression & Chiropractic Center

WELCOME

File _________

Patient Information

CONFIDENTIAL

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ***BLACK*** *ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help*. (Please Print)

Name____Date_____________ SSN_________________________
First MI Last

Address___________________________________ City ________________ State ________ Zip+4 __________________

Sex: ❑ Female ❑ Male ❑ Other Birth Date_____/_____/_____ E-Mail____

Home Phone____________________ Work Phone_____________________ Cell Phone ___________________________

Are you: ❑ Minor ❑ Married ❑ Divorced ❑ Widowed ❑ Single ❑ Separated

Your employer____Occupation________________________________

Business Address____City______________________State______Zip_______

Spouse's or Parent's name_______________________________Workplace______________Work Phone________________

Children's names and ages (optional)____

If you have Medicare coverage, give Subscriber's/Primary's name _________________________ & Date of Birth ___________

Whom may we thank for referring you to us?____

Person to contact in case of emergency_______________________________________ Phone___________________________

Financially Responsible Party

Name of person responsible for this account____

Relationship to patient ____Phone___________________________

Symptoms

Reason for visit?___________________________________ When did you first notice the symptom(s)? __________________

How did it start? ____

Is this condition getting progressively worse?____

Where specifically is the problem(s) located? ____

Which activities make it worse? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Laying down ❑ Other_______________

Type of Pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numb ❑ Aching ❑ Shooting ❑ Burning ❑ Tingling
❑ Cramping ❑ Stiff ❑ Swollen ❑ Other____

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant ❑ or does it come and go? ❑ When was the last time you had your spine checked?_______________

What treatment have you already received for your condition?

❑ Chiropractic ❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Other__________________________________

Names and locations (city, state) of other doctors who have treated you for your condition:_________________________________

____

Personal Health History

Check only those conditions which are applicable:

❑ AIDS/HIV	❑ Depression	❑ Hypertension	❑ Polio
❑ Alcoholism	❑ Diabetes	❑ Kidney Disease	❑ Prostate Problems
❑ Alzheimer's	❑ Emphysema	❑ Liver Disease	❑ Prosthesis________________
❑ Anemia	❑ Epilepsy	❑ Menstrual Cramps	❑ Psychiatric Care
❑ Anorexia	❑ Fractures	❑ Migraines	❑ Rheumatoid Arthritis
❑ Appendicitis	❑ Gout	❑ Miscarriage	❑ Stroke
❑ Arthritis	❑ Headaches	❑ Mononucleosis	❑ Suicide Attempt
❑ Asthma	❑ Heart Disease	❑ Multiple Sclerosis	❑ Thyroid Problem
❑ Bleeding Disorder	❑ Hepatitis	❑ Osteoporosis	❑ Tuberculosis
❑ Bronchitis	❑ Hernia	❑ Pacemaker	❑ Tumors, Growths
❑ Bulimia	❑ Herniated Disc	❑ Parkinson's Disease	❑ Ulcers
❑ Cancer________________	❑ Herpes	❑ Pinched Nerve	❑ Whooping Cough
❑ Chemical Dependency	❑ High Cholesterol	❑ Pneumonia	❑ ________________________

List any types of surgeries which you have had and the dates on which they occurred: ____

____

Please list all medications:____

Allergies: ____

WOMEN:

Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No HRT? ❑ Yes ❑ No

Daily Habits

What type of exercise do you perform on a regular basis?__________________________ How often?__________________________

What do your daily work habits include? (Ex: sitting, standing, light labor, heavy labor, computer work)

____

How many servings (½ cup) do you eat each day of dark, colorful fruits? ____________________ Vegetables?__________________

How many ounces of water do you drink each day (not including other fluids)? ____

What vitamins and/or other nutritional supplements do you currently take? ____

Do you smoke? ❑ Yes ❑ No How much per day? ___________________ How much alcohol per week? __________________

On a daily basis, how much coffee?________ (❑ regular ❑ decaf) How much soda? ________ What kind?____________________

What time do you go to bed? ________ Wake up? ________ When you wake up, do you feel rested? ❑ Yes ❑ No or ________%

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. By providing my contact information, I am authorizing Dr. Vince Baugher and staff to send directly to me my personal financial and medical records by way of electronic and verbal communications, including but not limited to appointment reminders and messages.

X____ ______________________________

SIGNATURE OF PATIENT (or parent if a minor) DATE

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in the cause and prevention of disease." – Thomas Edison

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