DISCOVER CHIROPRACTIC – Patient Information

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home #: _____ Mobile #:_____

Marital Status: ☐ Single ☐ Married Employer: _____ Occupation: _____

Social Security #: _____ Name of Insurance Co.: _____

Insured's Name: _____ Insured's DOB: _____

Name & Number of Emergency Contact: _____ _____Relationship: _____

Whom may we thank for referring you to this office? _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the primary problem begin? _____

How often? ☐ Constant **OR** ☐ On and Off during the ☐ Day ☐ Week ☐ Month

How did the injury happen? (Unknown) _____

Have you received treatment in the past? ☐No ☐ Yes When?: _____ by whom? _____

Name of Previous Chiropractor: _____ ☐ **N/A**

Please mark areas of complaint on the body diagram to the right:

What makes it better? _____

What makes it worse? _____

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

PAST HISTORY

Have you had this or a similar problem in the past? ☐ No ☐ Yes If so, when?_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past***, **C** for ***Currently*** have or **N** for ***Never*** have had**:**

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other:_____

PAST HISTORY (Continued)

Any past surgeries? ☐ No ☐ Yes _____

Have you ever been treated for cancer? ☐ No ☐ Yes _____

SOCIAL HISTORY

1. Smoking: ☐ Never ☐ Daily ☐ Weekends ☐ Occasionally
2. Alcoholic Beverage: ☐ Never ☐ Daily ☐ Weekends ☐ Occasionally
3. Recreational Drug use: ☐ Never ☐ Daily ☐ Weekends ☐ Occasionally
4. Exercise ☐ Never ☐ Daily ☐ Weekends ☐ Occasionally

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes ☐ Unknown
If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s) ☐ son(s) ☐ daughter(s)
2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

_____

REVIEW OF SYSTEMS

General: ☐ Weight loss/gain ☐ Fatigue ☐ Fever/chills ☐ Weakness ☐ Trouble sleeping
Skin: ☐ Rash ☐ Lumps ☐ Itching ☐ Dryness ☐ Discoloration ☐ Hair/nail changes
Head: ☐ Headache ☐ Head injury ☐ Concussion
Ears: ☐ Hearing loss ☐ Ringing ☐ Earache ☐ Drainage
Eyes: ☐ Vision change ☐ Pain ☐ Redness ☐ Blurred/double vision ☐ Cataracts ☐ Glaucoma
Nose: ☐ Nosebleeds ☐ Stuffiness ☐ Discharge ☐ Sinus ☐ Sneezing ☐ Hay fever
Throat: ☐ Sore throat/tongue ☐ Dry mouth ☐ Hoarseness ☐
Neck: ☐ Pain/stiffness ☐ Swollen glands ☐ Lumps
Breast: ☐ Lumps ☐ Pain ☐ Discharge ☐ Cancer
Lungs: ☐ Cough ☐ Phlegm ☐ Shortness of breath ☐ Wheezing ☐ Coughing up blood
Heart: ☐ Chest pain ☐ Palpitations ☐ Shortness of breath with activity ☐ Tightness in chest
Stomach/GI: ☐ Heartburn ☐ Ulcer ☐ Appetite change ☐ Nausea ☐ Bowel changes ☐ Constipation/diarrhea ☐ Bleeding
Urinary: ☐ Burning or pain ☐ Frequent ☐ Blood in urine ☐ Incontinence
Vascular: ☐ Calf pain with walking ☐ Leg cramps ☐ Cold/pale fingers/toes
Neuro: ☐ Dizziness ☐ Fainting ☐ Seizures ☐ Numbness/tingling ☐ Weakness ☐ Tremor
Musculo-Skeletal: ☐ Muscle/joint pain ☐ Stiffness ☐ Back pain ☐ Swollen joints ☐ Trauma

I hereby authorize payment to be made directly to DISCOVER CHIROPRACTIC for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to DISCOVER CHIROPRACTIC for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

PATIENT'S NAME: _____ HR#: _____ Date: _____