Dickinson family Chiropractic

Our Family Cares for Your Family

Welcome to our office. In order to provide you the best possible wellness care, please complete all forms legibly. If you have any questions or need assistance, feel free to notify the front administrative assistant. Please Print.

Today's Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

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

Telephone: (Home) _____ (Work) _____ (Cell) _____

Preferred Contact Number: (Circle) Home Work Cell Email: _____

Age: ___ Date of Birth: ___/ ___ /_____ Sex: M F Social Security #: _____

Martial Status: M S W D Number of Children: _____

Occupation: _____ Employer: _____

Spouse's Name: _____ Spouse's Employer: _____

Emergency Contact Name: _____ Emergency Contact # _____

Name of Primary Care Physician: _____ Referred by: _____

INSURANCE INFORMATION

Health Plan: _____ Subscriber's Name: _____

Subscriber's Date of Birth: ___/ ___ /_____ Subscriber's Social Security #: _____

Patient relationship to subscriber: _____ Subscriber's Employer: _____

Subscriber's address if differ than patient's: _____

CURRENT COMPLAINTS

Current Complaint: _____

Nature of injury: _____ Date of injury: ___/___/_____

Date symptoms appeared: ___/ ___ /_____ Have you ever had same condition? Y N If yes, when?_____

List of other practitioners seen for this injury/condition: _____

Have you ever been under chiropractic care? Y N

Name of previous chiropractor: _____ Last date of visit: _____

How often are your symptoms present? □ Constantly □ Frequently □ Occasionally □ Intermittently

Describe your current symptoms: □ Sharp/Stabbing □ Throbbing □ Aches □ Dull □ Soreness □ Weakness
□ Numbness □ Shooting □ Gripping □ Burning □ Tingling □ Other

Since it began, is your condition: □ Improving □ Getting Worse □ No Change

What makes the condition better: □ Nothing □ Lying Down □ Walking □ Standing □ Sitting
□ Movement □ Exercise □ Inactivity/Rest □ Other _____

On a scale of 0-10 (0 = no pain, 10 = worst possible), please rate severity of your symptoms:

0 1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

Weight: _____ Height: _____ Have you been treated for any conditions in the last year? Yes No

If yes, please describe _____

Date of last physical exam: _____

Have you had X-rays, MRI(s) and/or CT(s) taken? Yes No If yes, where? _____

What medications are you taking and for what conditions (please list dosage) _____

_____

What vitamins, minerals, or herbs do you currently take? _____

Have you ever:	*No*	*Yes*	*Briefly Explain*
Broken bones?	N	Y	_____
Been Hospitalized?	N	Y	_____
Been in an auto accident?	N	Y	_____
Had Sprains/Strains?	N	Y	_____
Been struck unconscious?	N	Y	_____
Had Surgery?	N	Y	_____
For Women:			
Are you pregnant?	N	Y	_____
Are you nursing?	N	Y	_____
Are you using birth control?	N	Y	Method: _____

FAMILY HISTORY

Family Members – Present and past health conditions:

	Heart Disease	Cancer	Diabetes	Arthritis	Other	
Mother	☐	☐	☐	☐	☐	_____
Father	☐	☐	☐	☐	☐	_____
Grandparents	☐	☐	☐	☐	☐	_____

Other illnesses and medical conditions: _____

Do you experience pain every day?	Yes	No
Do your symptoms interfere with daily living?	Yes	No
Does pain wake you up at night?	Yes	No
Are your symptoms worse during certain times of the day?	Yes	No
Do changes in weather affect your symptoms?	Yes	No
Do you wear orthotics?	Yes	No

HABITS	*None*	*Light*	*Moderate*	*Heavy*					
Alcohol	N	L	M	H	Appetite	N	L	M	H
Coffee	N	L	M	H	Soft Drinks	N	L	M	H
Tobacco	N	L	M	H	Water	N	L	M	H
Drugs	N	L	M	H	Salty Foods	N	L	M	H
Exercise	N	L	M	H	Sugary Foods	N	L	M	H
Sleep	N	L	M	H	Artificial Sweeteners	N	L	M	H

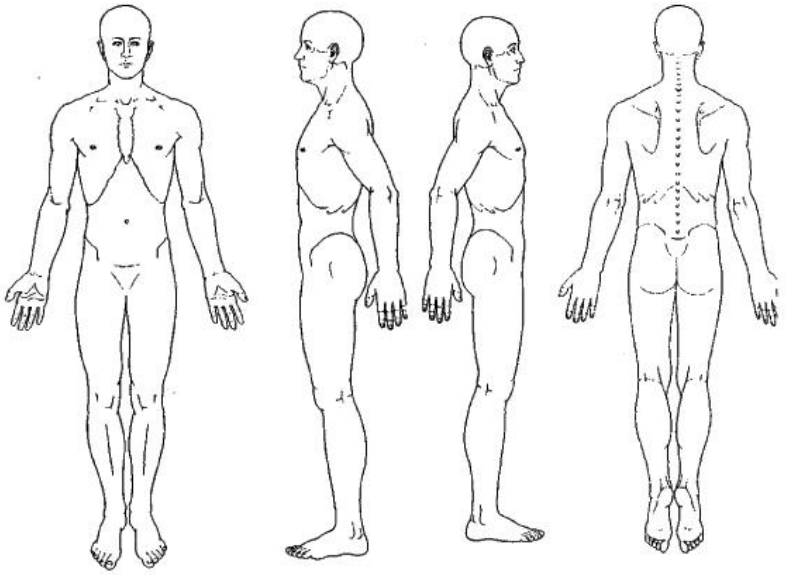
Have you ever suffered from:

□ Allergies	□ Constipation	□Hemorrhoids	□ Nosebleeds	□ Sleep Problems
□ Anemia	□ Cramps	□High Blood Pressure	□ Numbness in Fingers	□ Spinal Curvatures
□ Arteriosclerosis	□ Depression	□ Hot Flashes	□ Numbness in toes	□ Stoke
□ Arthritis	□ Diabetes	□ Infertility	□ Pacemaker	□ Swelling of ankles
□ Asthma	□ Digestion	□ Irregular Heart Beat	□ Back Pain	□ Dizziness
□ Kidney Infection	□ Poor Posture	□ Swollen Joints	□ Breast Lump	□ Ears Ring
□ Kidney Stones	□ Prostate Trouble	□ Thyroid Condition	□ Bronchitis	□ Sinus Infection
□ Sciatica	□ Tuberculosis	□ Bruise Easily	□ Fatigue	□ Ulcers
□ Cancer	□ Frequent Urination	□ Numbness in toes	□ Shortness of Breath	□ Cold Extremities
□ Chest Pain	□ Headache/Migraines	□ Nervousness	□ Excessive Menstruation	

Loss of: □ Balance □ Smell □ Taste ***Pins & Needles:*** □ Arms □ Legs

□ Other_____

Please use the following letters to indicate TYPE and LOCATION of the symptoms:



A = Ache **N** = Numbness
B = Burning **P** =Pins/Needles
S = Stabbing **O** = Other

AUTHORIZATION OF PAYMENT AND RELEASE OF RECORDS

I authorize the release of any medical or other information to process my insurance claim. This is to serve as a long-term authorization card. I authorize payment of medical benefits to Dickinson Family Chiropractic for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree that the above information is complete and accurate to the best of my knowledge. I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature _____ **Date** _____

CONSENT/NOTICE OF PRIVACY PRACTICES

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by the Doctor(s) of Chiropractic at Dickinson Family Chiropractic who now or in the future work at this office. I understand that the results of Chiropractic Care are not guaranteed. I understand that the Doctor will exercise judgment during the course of my treatment based upon the facts known to him/her, and any treatment rendered is in my best interest.
I have read, or have had read to me, the above consent. I agree to the above consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I have received the Notice Of Privacy Practices and I have been provided an opportunity to review it.

Patient Signature Or Legal Guardian _____ **Date**_____

Witness _____