



Precision Spinal Care
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Chesapeake, VA 23320
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nucspinalcare.com

CONFIDENTIAL
HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YY)

Patient Number (office use only)

First Name MI Last Name Name you like to go by

Address City State Zip

Email Address Best number to reach you about appointments (Cell) Prefer Call Text

Alternative Numbers: Home Phone Work Phone Other

Date of Birth Gender Male Female Marital Status Married Single Divorced Widowed Separated

Number of Children Social Security Number

Occupation/Job Description Employer

Insurance: Medicare BCBS Optima Atena United Tricare Self-Pay Other

Emergency Contact Emergency Contact's Phone Number

Are you here as the result of a: Car Accident Work Injury Something Else

Please describe why you are consulting the doctor:

How serious do you think this problem is:  Minimal  Moderate  Severe

What is your main goal?  Just a quick fix  Find a long term solution

What do you think will happen if you can't find a solution to your problem? \_\_\_\_\_

Describe what will be different in your life if you can get better. \_\_\_\_\_

What do you hope happens as a result of spending time with the doctor today? \_\_\_\_\_

In your mind, what is a resonal time for you to get better? \_\_\_\_\_

### Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please mark any condition that applies.

#### a. Musculoskeletal

- |  |  |  |  |                                     |                                       |
|--|--|--|--|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Osteoporosis  | <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Scoliosis         | <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Back Pain  | <input type="checkbox"/> Hip Disorder |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Foot/Ankle Pain | <input type="checkbox"/> Shoulder Problems | <input type="checkbox"/> Elbow/Wrist Pain    | <input type="checkbox"/> TMJ Issues | <input type="checkbox"/> Poor Posture |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Gout            | <input type="checkbox"/> Other _____       |  |                                     |                                       |

#### b. Neurological

- |                                   |   |  |  |                                     |   |
|-----------------------------------|---|--|--|-------------------------------------|---|
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Depression     | <input type="checkbox"/> Headache        | <input type="checkbox"/> Vertigo           | <input type="checkbox"/> Dizziness  | <input type="checkbox"/> Memory/Concentration |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Pins & Needles | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Parkinsons | <input type="checkbox"/> Multiple Sclerosis   |

#### c. Cardiovascular

- |  |   |   |                                     |   |   |
|--|---|---|-------------------------------------|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Heart Condition    |
|  |   | <input type="checkbox"/> Stroke           | <input type="checkbox"/> TIA        | <input type="checkbox"/> Angina           | <input type="checkbox"/> Excessive Bruising |
|  |   |   |                                     |   | <input type="checkbox"/> Arteriosclerosis   |

#### d. Respiratory

- |                                 |                                |                                    |                                    |  |                                    |
|---------------------------------|--------------------------------|------------------------------------|------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Apnea | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Allergies | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Pneumonia |
|---------------------------------|--------------------------------|------------------------------------|------------------------------------|--|------------------------------------|

#### e. Digestive

- |   |                                      |   |                                     |                                       |                                   |
|---|--------------------------------------|---|-------------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Ulcer       | <input type="checkbox"/> Food Sensitivities | <input type="checkbox"/> Heartburn  | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
|   | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Nausea             | <input type="checkbox"/> Overweight |                                       |                                   |

#### f. Sensory

- |   |  |                                       |  |  |  |
|---|--|---------------------------------------|--|--|--|
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Chronic Ear Infection | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Glaucoma       |  |                                       |  |  |  |

#### g. Skin

- |                                      |                                    |                                 |                               |                                    |                               |
|--------------------------------------|------------------------------------|---------------------------------|-------------------------------|------------------------------------|-------------------------------|
| <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Acne | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Rash |
|--------------------------------------|------------------------------------|---------------------------------|-------------------------------|------------------------------------|-------------------------------|

#### h. Endocrine

- |   |   |  |   |   |                                     |
|---|---|--|---|---|-------------------------------------|
| <input type="checkbox"/> Thyroid Issues | <input type="checkbox"/> Immune Disorders | <input type="checkbox"/> Hypoglycemia            | <input type="checkbox"/> Frequent Infection | <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Low Energy |
|   |   | <input type="checkbox"/> Diabetes Type I         | <input type="checkbox"/> Diabetes Type II   |   |                                     |
|   |   | <small>(hyperglycemia/insulin dependent)</small> | <small>(Insulin resistant)</small>          |   |                                     |

#### i. Genitourinary

- |  |                                      |                                     |  |   |                                       |
|--|--------------------------------------|-------------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Infertility | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Prostate Issues | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> PMS Symptoms |
| <input type="checkbox"/> STD           |                                      |                                     |  |   |                                       |

#### j. Constitutional

- |                                   |                                     |  |                                  |  |                                   |
|-----------------------------------|-------------------------------------|--|----------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Low Libido | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sudden Weight Gain/Loss | <input type="checkbox"/> Weakness |
|-----------------------------------|-------------------------------------|--|----------------------------------|--|-----------------------------------|

#### k. Diseases

- |                                   |                                     |                                 |  |  |                                       |
|-----------------------------------|-------------------------------------|---------------------------------|--|--|---------------------------------------|
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chicken Pox     | <input type="checkbox"/> Mumps         | <input type="checkbox"/> Measles      |
| <input type="checkbox"/> Malaria  | <input type="checkbox"/> Hepatitis  | <input type="checkbox"/> Polio  | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Typhoid  |                                     |                                 |  |  |                                       |

#### l. Female Only

- |   |                                   |   |   |   |                           |
|---|-----------------------------------|---|---|---|---------------------------|
| <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Cramping | <input type="checkbox"/> Heavy Bleeding | <input type="checkbox"/> Fertility Issues | Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of last cycle: _____ |
|---|-----------------------------------|---|---|---|---------------------------|

Patient Name

Patient Number

(office use only)

Consultation Notes

Doctor's Initials / Date

Past Surgeries: \_\_\_\_\_

Past Injuries: (car, sports, work, slip/fall, domestic, other) \_\_\_\_\_

Medications (prescription and over-the-counter)  Medication List Attached \_\_\_\_\_

Patient Name \_\_\_\_\_

Patient Number \_\_\_\_\_

(office use only)

**Family History**

Some health issues are hereditary. Tell us about the health of your immediate family members.

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Sibling 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Sibling 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Sibling 3	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Sibling 4	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Number of Children		_____					

**Social History**

Tell us about your health habits and stress level.

Eating Habits	<input type="radio"/> Healthy <input type="radio"/> Unhealthy <input type="radio"/> Planned Out <input type="radio"/> Grab on the go	Describe your work activity: _____ _____ _____ _____ _____
Weight	<input type="radio"/> Normal Weight for my height <input type="radio"/> Overweight <input type="radio"/> Underweight	
Water Intake	<input type="radio"/> Drink lots of water <input type="radio"/> Don't drink much water	
Exercise	<input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> None <input type="radio"/> Other _____	
Alcohol Use	<input type="radio"/> Frequent <input type="radio"/> Occasional <input type="radio"/> Social Drinker <input type="radio"/> None	
Pain Relievers	<input type="radio"/> Daily <input type="radio"/> Frequent <input type="radio"/> Occasional	
Soft Drinks	<input type="radio"/> Frequent <input type="radio"/> Occasional	
Tobacco Use	<input type="radio"/> Daily <input type="radio"/> Occasional <input type="radio"/> None	
Recreational Drugs	<input type="radio"/> Daily <input type="radio"/> Occasional <input type="radio"/> None	
Sleep	<input type="radio"/> Restful 7-8 hours night <input type="radio"/> Non-restful/wake up often/less than 6 hours	
Major Stress in life	<input type="radio"/> Work <input type="radio"/> Family/Relationship Situation <input type="radio"/> Health <input type="radio"/> Financial	
How do you handle stress	<input type="radio"/> Prayer <input type="radio"/> Exercise <input type="radio"/> Drink <input type="radio"/> Smoke <input type="radio"/> Overeat <input type="radio"/> Worry	
Hobbies:	_____ _____ _____	

Consultation Notes

**ACKNOWLEDGEMENTS:**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Precision Spinal Care will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized be paid directly to Precision Spinal Care will be credited to my account upon receipt of payment. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care, and have any balance for professional services already rendered that I am still responsible for payment of those services. Precision Spinal Care is a provider with Medicare and must follow all federal rules and regulations with Medicare which include no discounts or incentives may be offered.

Past due accounts will bear interest at 1.5% per month on the past due balance. I am responsible for costs required to enforce collection of my account, including, but not limited to collection fees, attorney fees and court costs. There is a \$35.00 bank charge for returned checks which is payable immediately. I hereby authorize the Doctor to treat my condition as he or she deems appropriate.

If the patient is a minor child, print child's full name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Doctor's Initials / Date