PRECISION
SPINAL CARE

Precision Spinal Care
1305 Executive Blvd., Suite 170
Chesapeake, VA 23320
757.382.5555
nuccaspinalcare.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

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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 reasonable 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

○ Osteoporosis	○ Arthritis	○ Scoliosis	○ Neck Pain/Stiffness	○ Back Pain	○ Hip Disorder
○ Leg/Knee Pain	○ Foot/Ankle Pain	○ Shoulder Problems	○ Elbow/Wrist Pain	○ TMJ Issues	○ Poor Posture
○ Arthritis	○ Gout	○ Other _____			

b. Neurological

○ Anxiety	○ Depression	○ Headache	○ Vertigo	○ Dizziness	○ Memory/Concentration
○ Numbness	○ Pins & Needles	○ Cold Hands/Feet	○ Epilepsy/Seizures	○ Parkinsons	○ Multiple Sclerosis
○ Loss of Bowel/ Bladder Control					

c. Cardiovascular

○ High Blood Pressure	○ Low Blood Pressure	○ High Cholesterol	○ Chest Pain	○ Poor Circulation	○ Heart Condition
○ Palpitations	○ Edema	○ Stroke	○ TIA	○ Angina	○ Excessive Bruising
					○ Areteriosclerosis

d. Respiratory

○ Asthma	○ Apnea	○ Emphysema	○ Allergies	○ Shortness of Breath	○ Pneumonia
○ Sputum with Cough	○ Blood with Cough				

e. Digestive

○ Anorexia/ Bulimia	○ Ulcer	○ Food Sensitivities	○ Heartburn	○ Constipation	○ Diarrhea
	○ Indigestion	○ Nausea	○ Overweight	○ Vomiting	

f. Sensory

○ Blurred Vision	○ Ringing in ears	○ Hearing Loss	○ Chronic Ear Infection	○ Loss of Smell	○ Loss of Taste
○ Glaucoma	○ Double Vision				

g. Skin

○ Skin Cancer	○ Psoriasis	○ Eczema	○ Acne	○ Hair Loss	○ Rash
○ Itching					

h. Endocrine

○ Thyroid Issues	○ Immune Disorders	○ Hypoglycemia	○ Frequent Infection	○ Swollen Glands	○ Low Energy
		○ Diabetes Type I (hyperglycemia/insulin dependent)	○ Diabetes Type II (Insulin resistant)		

i. Genitourinary

○ Kidney Stones	○ Infertility	○ Bedwetting	○ Prostate Issues	○ Erectile Dysfunction	○ PMS Symptoms
○ STD	○ Burning in Urination				

j. Constitutional

○ Fainting	○ Low Libido	○ Poor Appetite	○ Fatigue	○ Sudden Weight Gain/Loss	○ Weakness
○ Fever/Chills					

k. Diseases

○ HIV/AIDS	○ Alcoholism	○ Cancer	○ Chicken Pox	○ Mumps	○ Measles
○ Malaria	○ Hepatitis	○ Polio	○ Rheumatic Fever	○ Scarlet Fever	○ Tuberculosis
○ Typhoid					

l. Female Only

○ Menstrual Irregularity	○ Cramping	○ Heavy Bleeding	○ Fertility Issues	Pregnant ○ Yes ○ No	Date of last cycle: _____

Consultation Notes

Patient Name

Patient Number
(office use only)

Doctor's Initials / Date

Past Surgeries: _____

_____

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

_____

Medications (prescription and over-the-counter) ○ Medication List Attached _____

_____

Allergies _____

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	_____	○	○	_____	_____	○	○
Father	_____	○	○	_____	_____	○	○
Sibling 1	_____	○	○	_____	_____	○	○
Sibling 2	_____	○	○	_____	_____	○	○
Sibling 3	_____	○	○	_____	_____	○	○
Sibling 4	_____	○	○	_____	_____	○	○
Number of Children		_____					

Social History

Tell us about your health habits and stress level.

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

Describe your work activity:

_____

_____

_____

_____

_____

_____

_____

Hobbies: _____

_____

_____

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: _____/ _____ / _____

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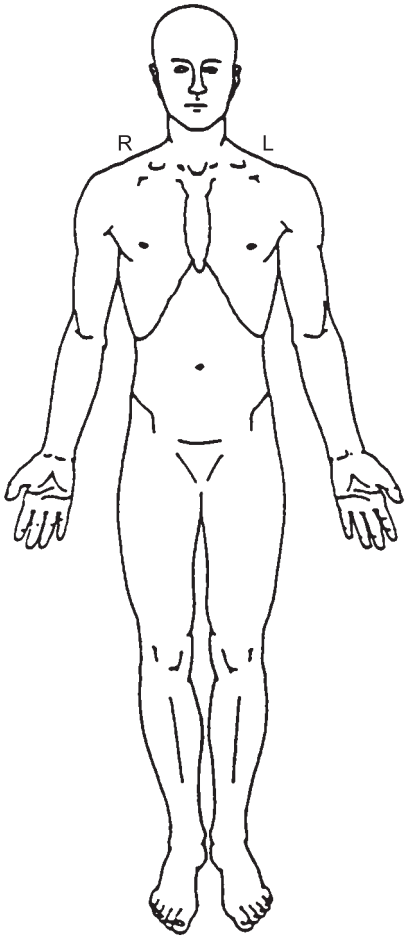
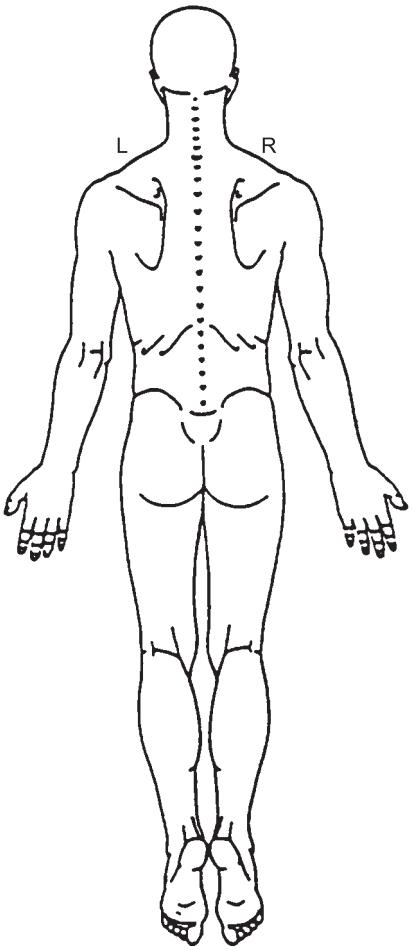
PAIN ASSESSMENT OVERVIEW

Patient Name _____

Patient Number _____
(office use only)

Location (Where does it hurt)?
Mark the area(s) on the illustrations where you hurt with an "X".





Consultation Notes:

PAIN ASSESSMENT OVERVIEW

Doctor's Initials / Date _____