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: ____________

____

____

____

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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? ____________________

____

Patient Name

Patient Number
(office use only)

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

c. Cardiovascular

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

d. Respiratory

○ Asthma ○ Apnea ○ Emphysema ○ Allergies ○ Shortness of Breath ○ Pneumonia

e. Digestive

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

f. Sensory

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

g. Skin

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

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

j. Constitutional

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

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

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: Good	State of health: Poor	Illnesses	Age at death	Cause of death: Natural	Cause of death: 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: ______________________________

____

____

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

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PRECISION
SPINAL CARE

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MECHANISM OF INJURY

Today's Date: ____________________

Patient's Name ____ **Patient #** ______________
(office use only)

Date of Accident ________________ **Location** ____

○ Auto ○ Work ○ Other

In your own words, please describe to the best of your knowledge, what happened during the accident: ____________________
____
____
____

You were: ○ In a car ○ A pedestrian ○ On a motorcycle ○ On a bicycle ○ Other ______________________
____

You were struck from: ○ Behind ○ Right side ○ Driver's left side ○ Front (head on) ○ Other ________________

Your car at the time of the accident: ○ Parked ○ In traffic, but stopped ○ Moving at approximately what speed __________

Other car at the time of the accident: ○ Parked ○ In traffic, but stopped ○ Moving at approximately what speed __________

What type of car were you in: Year ________ Make ________________ Model ________________

What type of car impacted your vehicle: Year ________ Make ________________ Model ________________

Were there any other impacts to your car after the initial impact: ○ Hit a 3rd vehicle ○ Stationary object ○ Other __________
____

At the time of impact were brakes applied: ○ Yes ○ No

Damage to your vehicle: ○ None ○ Minor ○ Moderate ○ Severe
Please Describe: ____
____

Damage to other vehicle: ○ None ○ Minor ○ Moderate ○ Severe
Please Describe: ____
____

Pictures of vehicle damage: ○ Yes ○ No **Doctor viewed pictures** __________ **(Date)**

Do you have current transportation: ○ Yes ○ No

What was your position in the car at the time of the accident: ○ Driver ○ Passenger front seat ○ Back seat behind driver
○ Back seat behind passenger seat ○ Other ____
____

At the time of impact were you: ○ Braced ○ Hit by surprise

PLEASE COMPLETE NEXT PAGE

Were any joints locked out at impact: ○ Foot on brake ○ Arms locked out on steering wheel ○ Other ______________________

What was your head/neck position at the time of impact: ○ Looking straight ahead ○ Turned to the right ○ Turned to the left ○ Looking up ○ Looking down ○ Other ______________________

Did you hit your head on any object: ○ No ○ Steering Wheel ○ Dash ○ Windshield ○ Headrest ○ Other ________________

Did you experience any flexion or extension of the neck at the time of impact: ○ Yes ○ No

What was the position of the headrest: ○ Below the level of my head ○ At the level of my head ○ Close enough to stop my head from backward motion ○ Angled to far back to stop my head from moving backward

Were you wearing a seat belt/lap restraint: ○ Yes ○ No Was the airbag deployed: ○ Yes ○ No

Were you knocked out unconscious at all after impact: ○ Yes If so, for how long: ______________ ○ No ○ Unsure

To the best of your ability, please describe the position your body moved at the time of impact and injuries you sustained: ______

____

____

Road Conditions: ○ Dry ○ Wet ○ Icy Do you have a police report: ○ Yes ○ No

Was it ○ Light ○ Dark If night was there adequate lighting: ○ Yes ○ No

Who was cited at fault: ○ Other driver ○ Driver of your car ○ Neither

Did you seek treatment the same day as the accident: ○ Yes ○ No

Taken by: ○ ambulance ○ self ○ other

Did you get examined by a medical provider after the accident: ○ Yes ○ No

Describe any exams or treatment provided to you prior to consulting our office:

Doctor/Facility: ____

Images taken: ____

Treatment prescribed: ____

_________ Images/radiology reports/medical notes requested

_________ Images reviewed _________ radiology report in file _________ medical notes in file

Describe any exams or treatment provided to you prior to consulting our office:

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Images taken: ____

Treatment prescribed: ____

_________ Images/radiology reports/medical notes requested

_________ Images reviewed _________ radiology report in file _________ medical notes in file

PLEASE COMPLETE NEXT PAGE

PRE-EXISTING CONDITIONS:

Please describe your general health condition prior to the accident: ______________________________
____
____

Did you have any previous: ○ MVA'S ○ Work Injuries ○ Other injuries If so, when: ______________________________

Symptoms: ______________________________

Treatment Provided: ______________________________

Date Released ______________________________

○ Resolved ○ Ongoing problems (please describe): ______________________________

Do you have open claims on any prior accidents: ○ Yes ○ No

Do you have any previous disability ratings: ○ Yes ○ No

Have you had prior spinal surgery: ○ Yes ○ No If so, do you have any spinal hardware: ______________________________
____

You have listed ______________________________ as your symptoms, are they:

○ New and did not exist prior to the accident

○ Had similar symptoms recently before the accident, but the accident made them:
○ mildly worse ○ moderately worse ○ severely worse

____
____
____

Were you actively under any treatment program prior to the accident: ○ Yes ○ No

Pre-existing assessment:

	Pre-accident serverity/freq/ ADL	Post-accident serverity/freq/ADL
1. ____________	____________	____________
2. ____________	____________	____________
3. ____________	____________	____________

Notes: ______________________________
____
____
____
____