MY CHIRO CARE

809 US 70 Hwy, Newton NC 28658

ABOUT YOU

First Name: _____ Middle: _____Last:_____

Street Address: _____

City: _____State: _____Zip Code: _____

Mobile Phone: _____-_____-_____ **Home Phone: _____-_____-_____**

Email Address: _____

Date of Birth: _____ /____/_____ *Is the patient under the age of 18*: **Yes / No**
Month Day Year

Gender: Male / Female

Height: _____'_____"

Weight: _____

Marital Status: *Single / Married / Separated / Divorced / Widowed/ Other*

Spouse Name (*if married*): _____

How Did You Hear About Us: (*circle any that apply*)

Word of Mouth / Advertisement / Social Media / Direct Marketing / Internet/ Other

What is your scheduled appointment (*if scheduled*)? _____

EMERGENCY CONTACT INFORMATION

Name: _____

Phone: _____-_____-_____ **Relation to you**: _____

REASON FOR CONSULATION

How long have you had this complaint? (***Circle's best answer***)

Less than 5 days (Acute) / Between 5-30 days (Sub Acute) / More than 30 days (Chronic)

What caused this condition? _____

What is the date this condition began? (*Skip if it's a car accident*) _____ / _____ / _____

What terms describe your discomfort best? _____

On the body diagram to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

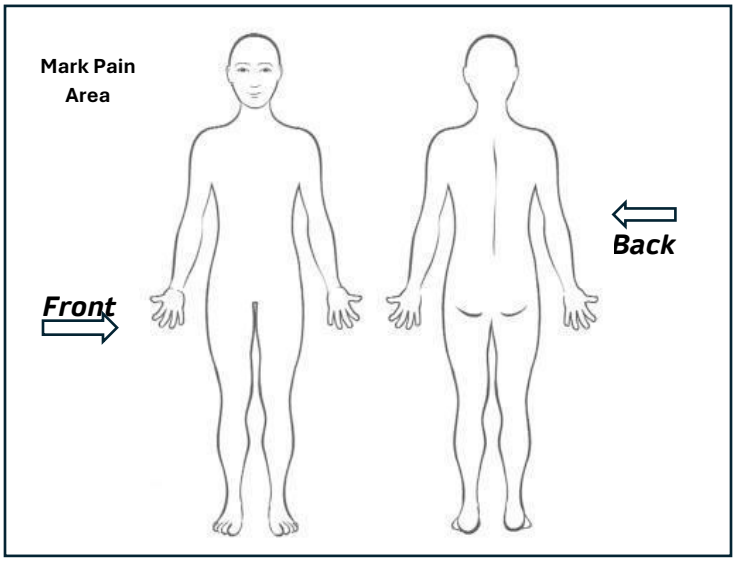
P- ***Pain***

N- ***Numbness***

W- ***Weakness***

S- ***Shooting***

A- ***Aching***



On a scale of 1 to 10, with 10 being the most severe, what is your current level of discomfort?

None Unbearable

0 1 2 3 4 5 6 7 8 9 10

How often do you feel this discomfort? *Constant / Frequent / Occasional / Intermittent*

How has this complaint changed since the onset? Worsened / Remain the same / Improved

What activity is most significantly affected by this discomfort? (Explain)

_____

What treatment have you received for this condition up to now?

_____

What aggravates this condition? _____

What improves this condition or gives you relief?

_____

Have other health care providers performed test related to this condition?

_____

Have you ever had any previous episode of this condition?

_____

Other than the information already provided, do you have any additional health concerns involving any of the following?

Muscle, Bones, or Joint	Yes/ No
Nerves, Headaches, Dizziness, or Emotional	Yes / No
Head, Eyes, Ears, Nose or Throat	Yes / No
Heart, Blood Pressure, or Circulation	Yes / No
Shortness of Breath, Coughing, Asthma or Lung Condition	Yes / No
Stomach, Bowels or Digestive Conditions	Yes / No
Diabetes, Thyroid or Glandular Conditions	Yes / No
Skin or Bleeding Conditions	Yes / No
Allergies or Sensitivities	Yes / No
Have you had any surgical Procedures?	Yes / No
Are there any past illnesses or conditions we should be aware of?	Yes / No
Do you have any history of accidents or trauma?	Yes / No
Are you presently taking any medication?	Yes / No
Are there any past illnesses or conditions we should be aware of?	Yes/ No
Do you have a past family illness history, such as diabetes, cancer, hypertension and progressive neurological disease that we should be aware of?	Yes / No

Current work habits: (*select all that apply)*

- ☐ Permanently fully disable
- ☐ Permanently partially disable
- ☐ Cannot work due to current condition
- ☐ Full time (20-40 hr/wk)
- ☐ Part time (1-19 hr/wk)
- ☐ Retired/Student/ Homemaker/Unemployed

Personal social habits: (*select all that apply)*

- ☐ Smoke or use tobacco products
- ☐ Drink alcohol
- ☐ Drink caffeine
- ☐ Use recreation drugs
- ☐ Other

Present exercise habits: (*select all that apply)*

- ☐ No current exercise
- ☐ Exercise daily
- ☐ Exercise 3+ times per week
- ☐ cannot exercise due to current condition

Diet and nutrition habits: (*select all that apply)*

- ☐ Vegan or vegetarian
- ☐ Daily supplements
- ☐ Other

MEN'S HEALTH (*skip this section if you're a female- Fill out page 5/6 on Women's Health***)**

Do you have pain or a lump in your scrotum or testicles? Yes / No

Do you have an impaired libido (*sex drive*)? Yes / No

Do you have discharge from your penis? Yes / No

Do you have prostate issues? Yes/ No

When was your last prostate exam?

- ☐ Within the past year
- ☐ Between 1 – 4 years
- ☐ Greater than 5 years
- ☐ Never had a prostate exam
- ☐ Prefer not to answer or do not know

When was your most recent PSA (*Prostate Specific Antigen*) blood test?

- ☐ Within the past year
- ☐ Between 1 – 4 years
- ☐ Greater than 5 years
- ☐ Never had a PSA blood
- ☐ Prefer not to answer or do not know

When was your PSA (*Prostate Specific Antigen*) level on your latest test?

- ☐ Within the past year
- ☐ Never had a PSA level done
- ☐ Between 1 – 4 years
- ☐ Greater than 5 years
- ☐ Prefer not to answer or do not know

WOMEN'S HEALTH (*skip this section if you're a male- Fill out page 4/6 on Men's Health*)

Are you pregnant? Yes / No

Are you nursing? Yes / No

Are you taking birth Control? Yes / No

Do you experience painful periods? Yes / No

Do you have irregular cycles? Yes / No

Do you have breast implants? Yes / No

Do you perform a regular self-breast examination? Yes / No

Do you take Hormone Replacement Therapy? Yes / No

Do you take oral contraceptives? Yes / No

When was your last PAP/ pelvic exam?

- ☐ Within the past year
- ☐ Between 1 – 4 years
- ☐ Greater than 5 years
- ☐ Never had a PAP or Pelvic exam
- ☐ Prefer not to answer or do not know

What was the date of your last menstrual period? (*only answer if still menstruating***)**

- ☐ Within the past month or currently
- ☐ Between 1 – 3 months
- ☐ Greater than 3 years
- ☐ Postmenopausal
- ☐ Have not yet begun menstruation
- ☐ Prefer not to answer or do not know

When was your last mammogram?

- ☐ Within the past year
- ☐ Between 1 – 4 years
- ☐ Greater than 5 years
- ☐ Never had a mammogram exam
- ☐ Prefer not to answer or do not know

Initial: _____

CONSENT FOR TREATMENT

I certify that I am the patient or legal guardian listed above. I have read/ understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this chiropractic office. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for the timely payment of such services. I understand and agree that health / accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: _____ Date: _____ / _____ / _____

Legal Guardian Signature: _____Date: _____/ _____/ _____
(*Legal Guardian sign if a patient is under 18 years old*)