Confidential Patient Information

Full Name: _____ Date: ___/___/____
First MI Last

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

Address: _____
Street City State Zip

Date of Birth: ____/____/____ Age: _____ # of Children: _____

Drives License #: _____ SS#: _____ e-mail address: _____

Employer: _____

Occupation/Job Description: _____

Marital Status: (Please circle) Married Single Widow/Widower Divorced

Name of Spouse/Legal Guardian: _____ Address: _____

Spouse or legal guardian employer: _____

Name of nearest relative not living with you: _____

Relationship: _____ Phone: (____)_____ Address: _____

How did you hear about our clinic? _____ May we send them a thank you? Y____ N____

Insurance Information

Primary Insurance: _____ Policy # _____ Group # _____

Name of insured: _____ Date of Birth: _____

Secondary Insurance: _____ Policy # _____ Group # _____

Name of insured: _____ Date of Birth: _____

Who is responsible for paying for the services rendered?_____

Is this a **Work related** injury that would be covered by **Workers Compensation. Insurance**? Y____N ____

If so, name of work comp. ins. _____ Address _____

Is this a **Personal Injury or Auto Accident** case? ___yes ____no

If so, name of insurance_____ Claim Number: _____

Insurance coverage is a contract between the patient, their employer and the insurance company. We will file the claims, but the patient is responsible for payment. Please see our financial policy for details.

Examination and x-rays that are required for diagnosis and treatment of Medicare patients **ARE NOT** covered by Medicare.

Signature _____

Office Use Only
X-ray # _____
Date: _____

Dietrich Chiropractic, SC

Patient Symptoms Questionnaire

Patient's Name:_____ Date:____/____/____

1. Present complaint: _____ Date of Birth ____/____/____

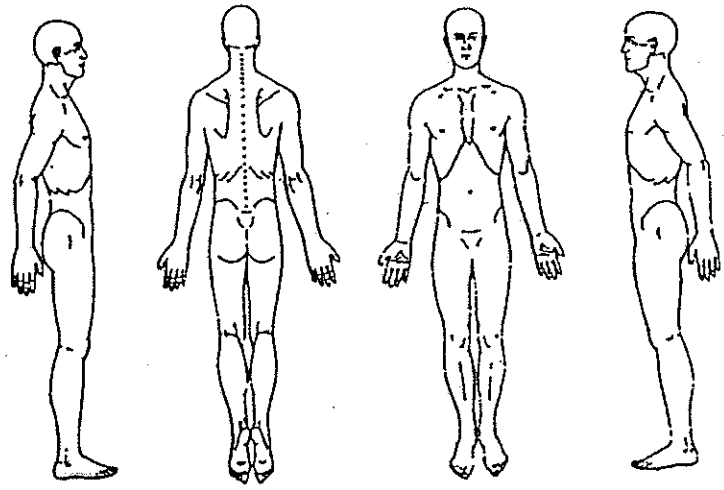
a. Description

- ☐ Sharp pain
- ☐ Dull pain
- ☐ Ache
- ☐ Weak
- ☐ Throbbing
- ☐ Numb
- ☐ Shooting
- ☐ Gripping
- ☐ Burning
- ☐ Tingling

b. Frequency

- ☐ Constant (76-100%)
- ☐ Frequent (51-75%)
- ☐ Occasional (26-50%)
- ☐ Intermittent (25%or less)

Mark on the picture where you have pain or other symptoms.



c. Indicate the intensity of your pain at its lowest and highest level:

NO PAIN 1 2 3 4 5 6 7 8 9 10 UNBEARABLE

d. Since your problem began, is the pain: ☐ Increasing ☐ Decreasing ☐ Not changing

e. Symptoms are worse in the ☐ morning ☐ afternoon ☐ night ☐ increases during the day ☐ same all day

2. When did your problem begin (Specific date if possible)?_____

3. Did your problem begin:
☐ Immediately after a specific incident ☐ Multiple incidents ☐ Gradually developed over time ☐ No specific reason?

4. Describe how your problem began:_____

_____

5. Have you been treated for this episode? ☐ Yes ☐ No If yes, by whom?
☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other _____
Are you currently being seen? ☐ Yes ☐ No When?____/____/____ What treatment?_____

_____

6. ***In the past*** have you been treated for the same or a similar condition? ☐ Yes ☐ No If yes, who did you see for that episode?
☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other _____
When? ____/____/____ What treatment? _____

7. What makes your problem worse?
☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement or exercise ☐ Inactivity ☐ Other _____

8. What makes your problem better?
☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement or exercise ☐ Inactivity ☐ Other: _____

9. How would you rate your current stress level? ☐ No stress ☐ Minimal Stress ☐ Moderate stress ☐ Greatly stressed

10. Physical activity at work:
☐ Sit more than 50% of workday ☐ Light manual labor ☐ Manual labor ☐ Heavy manual labor ☐ Repetitive motion

11. General physical activity: ☐ No regular exercise ☐ Light exercise ☐ Moderate exercise ☐ Strenuous exercise

12. How are your complaints affecting your ability to be active?
- ☐ No effect
- ☐ Need limited assistance w/common tasks
- ☐ Have significant inability to function without assistance
- ☐ Some physical restrictions (able to perform light duties)
- ☐ Need assistance often
- ☐ Totally disabled

13. Occupation:_____ ☐ FT ☐ PT Has your work status changed due to this complaint? ☐ Yes ☐ No

(Confidential)

Health History

Patient Name _____ Date _____

Age _____ Birthdate _____ Date of last physical exam: _____

Symptoms

Check (√) conditions you currently have or have had.

MUSCULOSKELETAL

PAST	NOW	
☐	☐	Neck pain
☐	☐	Headache
☐	☐	Upper back pain
☐	☐	Shoulder pain
☐	☐	Pain in upper arm or elbow
☐	☐	Wrist pain
☐	☐	Hand pain
☐	☐	Low back pain
☐	☐	Pain in upper leg or hip
☐	☐	Pain in lower leg or knee
☐	☐	Pain in ankle or foot
☐	☐	Jaw pain
☐	☐	Swelling /stiffness of joints

GENERAL

☐	☐	Change in weight
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Fever
☐	☐	Loss of sleep
☐	☐	Numbness

CARDIOVASCULAR

PAST	NOW	
☐	☐	Aortic Aneurysm
☐	☐	Chest pain/Angina
☐	☐	Heat attack/stroke
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Poor circulation
☐	☐	Irregular heart beat
☐	☐	Rapid heart beat
☐	☐	Swelling of ankles
☐	☐	Varicose veins

EYE, EAR, NOSE, THROAT

☐	☐	Bleeding gums
☐	☐	Blurred vision
☐	☐	Difficulty swallowing
☐	☐	Double vision
☐	☐	Earache
☐	☐	Hay fever
☐	☐	Loss of hearing
☐	☐	Nosebleeds
☐	☐	Persistent cough
☐	☐	Ringing in ears
☐	☐	Sinus problems
☐	☐	Visual disturbances

GASTROINTESTINAL

PAST	NOW	
☐	☐	Bloating
☐	☐	Bowel changes
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Excessive hunger
☐	☐	Excessive thirst
☐	☐	Gas
☐	☐	Hemorrhoids
☐	☐	Indigestion
☐	☐	Nausea
☐	☐	Poor appetite
☐	☐	Stomach pain
☐	☐	Vomiting

GENITO-URINARY

☐	☐	Blood in urine
☐	☐	Frequent urination
☐	☐	Lack of bladder control
☐	☐	Painful urination

WOMEN only

☐	☐	Extreme menstrual pain
☐	☐	Hot flashes
☐	☐	Irregular menstrual flow
☐	☐	Other_____

Conditions

Check (√) conditions you currently have or have had.

PAST	NOW	
☐	☐	Acid Reflux
☐	☐	AIDS
☐	☐	Alcoholism
☐	☐	Anemia
☐	☐	Anorexia
☐	☐	Appendicitis
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Bleeding disorders
☐	☐	Breast lump
☐	☐	Bronchitis
☐	☐	Bulimia
☐	☐	Cancer
☐	☐	Chemical dependency
☐	☐	Chicken Pox
☐	☐	Depression
☐	☐	Diabetes
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fibromyalgia
☐	☐	Glaucoma
☐	☐	Goiter
☐	☐	Gout
☐	☐	Heart Disease
☐	☐	Hepatitis
☐	☐	Hernia
☐	☐	High Cholesterol
☐	☐	HIV positive
☐	☐	Kidney disease
☐	☐	Liver disease
☐	☐	Measles
☐	☐	Migraine headaches
☐	☐	Miscarriage
☐	☐	Mononucleosis
☐	☐	Multiple Sclerosis
☐	☐	Mumps
☐	☐	Pacemaker
☐	☐	Pneumonia
☐	☐	Polio
☐	☐	Prostate problem
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Scoliosis
☐	☐	Stroke
☐	☐	Thyroid problems
☐	☐	Tonsillitis
☐	☐	Tuberculosis
☐	☐	Typhoid Fever
☐	☐	Ulcers

Medications

List medications you are currently taking.

Allergies

Pharmacy Name _____ Phone _____

Family History

Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) if, your blood relatives had any of the following: Disease	Relationship to You
Father					☐ Arthritis, Gout	
Mother					☐ Asthma, Hay Fever	
Brothers					☐ Cancer	
					☐ Chemical dependency	
					☐ Diabetes	
					☐ Heart Disease, Stroke	
Sisters					☐ High blood pressure	
					☐ Kidney Disease	
					☐ Tuberculosis	
					☐ Other	

Hospitalizations/Surgeries/Broken Bones

Year	Reason for Hospitalization or Surgery & Outcome

Pregnancies

	Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (√) which substances you use and describe how much you use.

☐ Caffeine	
☐ Tobacco	
☐ Alcohol	
☐ Other	

Disability Ratings

Do you have a permanent disability rating? ☐ YES ☐ NO

If yes, location_____

Date rating was received_____

Percentage of rating_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature Date

Reviewed By Date