

Patient Information - Deerpath Chiropractic Clinic

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Primary Phone _____ Secondary Phone _____ Mobile Phone _____
Email _____ Birthdate _____ Gender: Male Female
Marital Status: Single Married Other: _____ Employment: Employed Student Retired Other
Employer _____ Occupation _____
Employer Address _____ City _____ State _____ Zip _____
Spouse or Patient's Name _____ Employer _____
Person to contact in case of emergency _____ Phone _____
How did you hear about our office? _____ If internet, what website _____

Insurance Information – If insured, please provide your insurance card(s) to be copied.

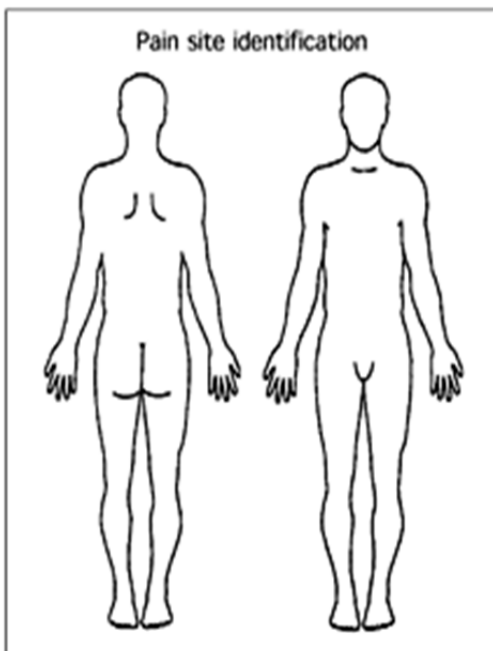
Insurance Co. _____ Additional Insurance _____
If patient is not the policy holder: Name of Policy Holder _____ Birthdate _____
Relationship to patient _____ Employer _____

Certification and Assignment

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the doctor to diagnose and treat my condition(s). Further, I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. This shall remain in effect until revoked by me in writing.

Signature of Patient/Parent/Guardian _____ Date _____

Symptoms



Reason for visit: _____
When did this problem start? _____
How did your symptoms start? _____
Are there any activities or movements that are difficult to perform?

Mark each area on the picture indicating where you have pain or other symptoms, and indicate **AREA 1,2,3...**

Circle your average pain intensity on the scale:

Area 1: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Area 2: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Area 3: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Type of pain **Area 1** (circle): dull sharp throbbing burning deep aching
tingling stabbing cramping numbness radiating other _____

Area 2: _____ **Area 3:** _____

How often do you have the pain? **Area 1** (circle): Daily / _____ times/week / _____ times/month / other _____
.....**Area 2:** _____ **Area 3:** _____

When you have the pain, how frequent is it? **Area 1:** (circle - % of time):
Constantly (75%-100%) Frequently (50%-75%)
Occasionally (25%-50%) Intermittently (0%-25%)
..... **Area 2:** _____ **Area 3:** _____

Where does your pain radiate or spread to? **Area 1:** _____ **Area 2:** _____ **Area 3:** _____

Does anything aggravate the pain? _____ Does anything relieve the pain? _____

When is your pain at its worst? _____ At its best? _____

What treatment/testing have you received for your condition(s)? _____

Name(s) of doctor or therapist _____

What exercise do you do regularly? _____ What is your major working activity/position? _____

(Note: Many of the following questions are due to new government requirements)

Health History – please circle all that apply Severe Headaches / Chest Pain / Angina / Kidney Stones / Digestive problems / **Hypertension** / Renal disease / Gout / Stroke / Heart Disease / **Diabetes** / Arthritis / Epilepsy / Arrhythmia / Endocrine Disease / Aids/HIV / Fatigue / Genital-Urinary Problems / Dizziness / Fainting / Anemia / Rheumatic Fever / Scarlet Fever / Prostate Problems / Ulcers / Gallstones / Sexual Dysfunction / Venereal disease / Pancreatitis / Shortness of Breath / Menstrual Dysfunction / Mental Illness / Asthma / Liver Disease / Alcohol or Drug Problems / Bleeding Disorders / Cancer / Fractures / Herniated Disc / High Cholesterol / Osteoporosis / Pacemaker / Parkinson's / Prosthesis / Implants / Rheumatoid / Fibromyalgia / **Smoke Tobacco** / Other(s) _____
Explanation(s) if necessary _____

Briefly list any other active health problems: _____

Please list all surgeries, hospitalizations or significant injuries: _____

(Women) Are you pregnant or could you potentially be pregnant? Yes No Due Date: _____

Race (circle) White / Black/African American / Hispanic / American Indian/Alaskan Native / Asian / Asian Indian / Chinese / Filipino / Japanese / Korean / Vietnamese / Native Hawaiian or other Pacific island / Samoan / Guamanian or Chamorro / Other _____ / I choose not to specify

Multi-Racial (circle) Yes No Unknown

Ethnicity (circle) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language, if not English: _____

Verification Question – for electronic records (choose only one question by circling the question, then give the answer)

What is the name of your favorite pet? In what city were you born? What high school did you attend? What is your favorite movie? What is your mother's maiden name? On what street did you grow up? What was the make of your first car? When is your anniversary? What is your favorite color? Verification question answer: _____

Current medications, including dosage: If no medications, check here: 1. _____
2. _____ 3. _____

List any known medication allergies: If no allergies, check here: 1. _____
2. _____ 3. _____

Have you been diagnosed with Diabetes? Yes No If yes, Type I or Type II _____
If yes to diabetes, was your blood work for hemoglobin A1c > 9.0%? Yes No Not Sure

To be performed by staff: Height _____ in. Weight _____ lbs. BP _____/_____