PATIENT PERSONAL / CONFIDENTIAL DATA

SS#_____ Date: _____

Patient Name: _____ DOB: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Permission to leave a detailed telephone message: Yes ☐ No ☐

Employer: _____ Address: _____

How did you learn about this clinic: _____

Who is responsible for payment? ☐ Self ☐ Spouse ☐ Other _____

Email Address: _____

Would you like to receive Our Tricare Chiropractic Monthly Newsletter? Yes☐ No ☐

Purpose of this appointment and list your complaints:

_____

_____

_____

Date of Injury: _____ Time: _____A.M. or P.M.

Location: _____

How did the accident occur? ☐ Auto ☐ on the Job ☐ Other, _____

Please describe the circumstances and what makes the condition(s) better or worse.

_____

_____

_____

Have you seen another Doctor for this condition? Yes or No Doctor's Name: _____

Your primary Doctor: _____ Phone #: _____

Insurance Information

I understand and agree the health and accident insurance policies are and agreement between the insurance carrier and myself. Furthermore, I understand that this chiropractic Office will prepare necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Office Will be credited to my account upon receipt, However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional serviced rendered to me will immediately do and payable.

Patient's Signature: _____

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic service that he/she deems necessary in my case. As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. These complications include fractures, disk injuries and stroke. I further authorize him/her to disclose all or any part of my (patients) records to any persons or corporation in which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient's Signature: _____

Patient's or Guardian's Signature: _____

HEALTH QUESTIONNAIRE

MUSCULO SKELETAL VASCULAR SYSTEM

- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Broken bones
- ☐ Shoulder pain

GENITO-URINARY SYSTEM

- ☐ Bladder
- ☐ Excessive Urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

GASTRO-INTESTIONAL SYSTEM

- ☐ Poor Appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult Swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble

CARDIO- SYSTEM

- ☐ Chest Pain
- ☐ Pain over heart
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

Nervous System

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscles jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

Eye, Ear, Nose AND Throat

- ☐ Eye stain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noise
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Difficult breathing through nose
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Sinus
- ☐ Allergy
- ☐ Jaw pain

HABITS

- ☐ Cigarettes
- ☐ Alcohol Abuse
- ☐ Coffee or Tea
- ☐ Drug Abuse
- ☐ _____

FEMALE

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on the breast

ARE YOU PREGNANT?

☐ **YES** ☐ **NO**

Patient's Signature _____

Patient Accepted? ☐ **Yes** ☐ **No**

Doctor's Signature _____

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at the worst.

PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES HOW YOUR TYPICAL PAIN LEVEL AFFECTS THESE SIX CATEGORIES OF ACTIVITIES.

1 **Family/ at home responsibilities such as yard work, chores around the house or driving the kids to school –**

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2 **Recreation including hobbies, sports or other leisure activities –**

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3 **Social activities including parties, theater, concerts, dining – out and attending other social functions –**

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4 **Employment including volunteer work and homemaking tasks –**

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5 **Self- care such as taking a shower, driving or getting dressed –**

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6 **Life- support activities such as eating and sleeping –**

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

PATIENT NAME _____ DATE_____