

Academy Park Chiropractic, P.C.

Dr. Kevin R. Portenier
Dr. Thomas C. O'Hollearn

About You

Name: _____ Date: _____

Preferred Name: _____ Age: _____ Birthdate: ____/____/____

Address: _____ Apt#: _____

City/State: _____ Zip: _____

Home Phone#: _____ Cell Phone#: _____

E-mail: _____

Referred By: _____

Marital Status (Circle One): Married Single Divorced Widowed Other

Name of Significant Other: _____

Your Employer: _____ Phone#: _____

Occupation: _____

Reason For Visit

Please circle the reason(s) for your visit:

Work Sports Auto Trauma Chronic

Please Explain: _____

Please describe the pain & it's location: _____

When did condition begin? ____/____/____ Is this condition getting worse? Y N

Have you been treated by a medical physician for this condition? Y N

PAIN RATING & DRAWING

PATIENT NAME _____

DATE _____

HOW LONG HAVE YOU HAD THIS PAIN? _____

WITHIN THE LAST COUPLE OF DAYS TO A WEEK PLEASE RATE YOUR LEVEL OF PAIN AND FREQUENCIES.

Pain Levels: Using a 0 – 10 Pain Scale (0 = No pain, 10 = Most intense pain imaginable)

Rate your current level of pain _____, percent of time at this level of pain _____%.

Rate your average pain level _____, percent of time at this level of pain _____%.

Rate the worst your pain gets _____, percent of time at this level of pain _____%.

Rate the lowest your pain gets _____, percent of time at this level of pain _____%.

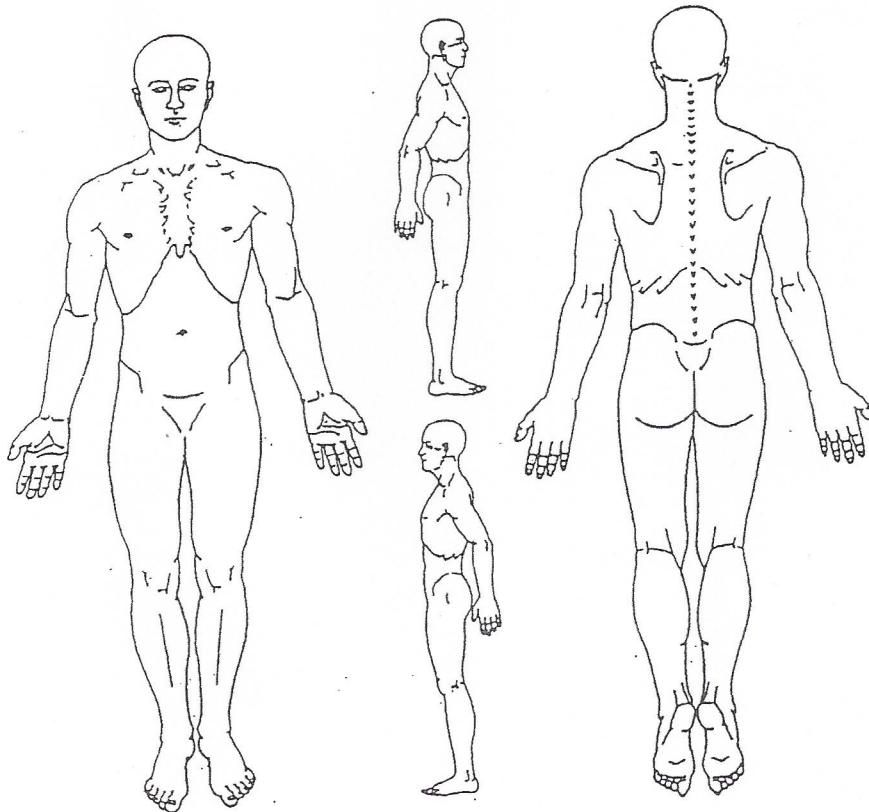
What things are you unable to do or must modify to perform? _____

What will bring on or intensify your pain? _____

KEY

USE LETTERS BELOW TO INDICATE TYPE AND LOCATION OF DISCOMFORT

A = ACHE	B = BURNING	C = STABBING
N = NUMBING	P = PINS & NEEDLES	O = OTHER



Check symptoms you have noticed: Use N if problem Now Use P if problem in the Past Leave blank if OK

() Headaches	() Pain in shoulder	() Low back pains
() Head feels heavy	() Muscle spasm in shoulder	() Low back muscle spasm
() Light headed	() Pain in neck	() Pain into buttock
() Loss of balance	() Stiff neck	() Pain into thigh
() Dizzy	() Muscle spasms in neck	() Pain down leg
() Nervous	() Pain in arm and hand	() Pain in ankle
() Fatigue	() Pins and needles in arms/hands	() Pain in foot
() Loss of hearing	() Loss of grip strength	
() Blurred vision	() Mid back pain	
() Chest pain	() Pain between shoulders	

TODAYS PAIN OR PROBLEM STARTED WHEN _____

PAINS ARE: SHARP _____ DULL _____ CONSTANT _____ INTERMITTENT _____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? _____

WHAT ACTIVITIES LESSEN YOUR CONDITION? _____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY? _____

IS THIS CONDITION INTERFERING WITH WORK? _____ SLEEP? _____ ROUTINE? _____

IS CONDITION GETTING PROGRESSIVELY WORSE? _____

OTHER DOCTORS SEEN FOR THIS CONDITION _____

ANY HOME REMEDIES _____

PREVIOUS SERIOUS ILLNESS: (Please list & describe) CANCER _____ FRACTURES _____

If you are accepted as a patient you are expected to pay at the end of each visit unless other arrangements are approved

Date _____ Patient/Parent Signature _____

This office will gladly prepare medical claim forms, but we cannot render services on the assumption that our charges will be paid by an insurance company
You are responsible for payment whether or not paid by insurance

ASSIGNMENT OF BENEFITS AND POWER OF ATTORNEY TO CASH CHECKS

I, the undersigned, do hereby authorize payment directly to the office below, the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. If these payments are made out to me I grant unto the office below as attorney the full power and authority in my name and stead to endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid

Date _____ Patient's Signature _____

AUTO AND OTHER ACCIDENTS - NOTICE OF LIEN TO ATTORNEY

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him
I have received a copy of this document

Date _____ Patient's Signature _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said doctor above named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Date _____ Attorney's Signature _____

PATIENT HISTORY DISCUSSION

NAME: _____ DATE: _____

Primary Complaint?

Duration of Condition?

Had problem previously?

What previous treatment?

What are you doing for it now?
Have you found that effective?

If another Doctor seen for this problem, what advice was given?

Other Doctors seen for any reason, including pregnancy?

Are you taking any drugs? What?

Have you ever had any serious falls, accidents, strains, etc?

Have you ever been hospitalized, had surgery or a lengthy illness?

Have other members of your family had a similar problem?

Has this problem interfered with your job?

How has this problem affected your living habits?

Have you noticed other related symptoms such as _____?