CONFIDENTIAL PATIENT INFORMATION

Name_____ Date_____
Address_____ City_____ State_____ Zip_____
Cell Phone (Primary Phone) (____)_____ E-mail_____ Sex: ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er) Birthdate_____ Age_____

# of Children_____ SS#_____ Driver's License Number_____
Health Insurance (Name)_____
Business/Employer_____ Address_____ City_____
Type of Work_____ ☐ Full or ☐ Part Time Business Phone (____)_____ Ext.____

Person Responsible For This Account_____ Referred To This Office By_____
Nearest Relative Not Living With You_____ Phone (____)_____
Name of Emergency Contact_____ Relationship_____ Phone (____)_____
Spouse's Name_____ Birthdate_____ SS#_____
Spouse's Employer_____ Spouse's Cell Phone (____)_____
What Is Your Major Complaint?_____
When Did This Condition Begin?_____ Has This Condition Occurred Before? ☐ Yes ☐ No

List Any Activities, Accidents or Injuries That Contributed to the Onset of Your Condition_____
_____
Is Your Condition ☐ Job Related ☐ Auto Related ☐ Home Injury ☐ Fall ☐ Other_____

Date Of Accident_____ Time Of Accident_____
Have You Reported This Accident To Your Insurance Company, Employer or Auto Insurance? ☐ Yes ☐ No

What Activities Aggravate Your Condition?_____
Is This Condition Interfering With ☐ Work ☐ Sleep ☐ Activities of Daily Living ☐ Other_____

How?_____
Have You Seen Any Other Doctors For This Condition? ☐ Yes ☐ No Doctor's Name_____

Diagnosis_____ Type Of Treatment_____
Length Of Care_____ Are You Still Under Care?_____ Results_____
Do You Wear A Shoe or Heel Lift? ☐ Yes ☐ No Do You Wear Orthotics? ☐ Yes ☐ No

List Current Medical Conditions for Which You Are Being Treated Or Suffer From_____
_____
Current Medications (Prescription and Over-the-Counter)_____
_____
Current Supplements (Vitamins, etc.)_____
Previous Surgeries (Please Provide Dates)_____
_____
Previous Accidents or Injuries (Please Provide Dates) (Especially Those That Relate to Your Current Problem…Falls, Broken Bones, Auto Accidents, Head Trauma, Sports Injuries, Etc.)_____
_____
Illnesses and/Or Hospitalizations_____
Family History: List Medical Conditions That Your Parents and Siblings Suffer(ed) From_____
_____
Previous Chiropractic Care ☐ No ☐ Yes Doctor's Name_____ Date of Last Visit_____

Were You Satisfied With Care?_____
Family Physician_____ Date of Last Visit_____

I 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 services rendered to me will be immediately due and payable.

Patient's Signature_____ Date_____
(Legal Guardian, If Minor)

Name_____ Date_____ Birthdate_____

PAST MEDICAL HISTORY: Place an "X" next to conditions that you currently or previously experience(d).

___Acid reflux or ulcers
___Anemia
___Aneurysm
___Arm pain
___Arthritis
___Allergies_____
___Asthma or Bronchitis
___Alcoholism
___Alzheimer's disease
___Back pain
___Blood vessel disease
___Cancer_____
___Chronic fatigue
___Carpal Tunnel Syndrome
___Circulatory problems
___Colon problems
___Depression
___Diabetes
___Drug addiction
___Eating disorder
___Epilepsy/Seizures
___Fainting
___Fibromyalgia
___Glaucoma
___Headaches or migraine
___Heart attack
___Heart disease
___High blood pressure
___High cholesterol
___Herniated disk
___Kidney or bladder disease
___Leg pain
___Liver or gallbladder
___Low blood sugar
___Mental illness
___Neck pain
___Neurological problems
___Obesity
___Osteoporosis
___Sinus problems
___Skin problems
___Stroke or TIA
___Thyroid problems
Other_____

Next to each symptom that you are <u>currently</u> experiencing, identify how often the symptom occurs by placing either an *<u>0</u> = Occasional (Off and On), <u>F</u> = Frequent (Most of the time), or <u>C</u> = Constant (All of the time)*

HEAD
___Headache
___Sinus (allergy)
___Entire Head
___Back of Head
___Forehead
___Temples
___Migraine
___Loss of Memory
___Light-Headedness
___Fainting
___Light Bothers Eyes
___Blurred Vision
___Double Vision
___Loss of Vision
___Loss of Taste
___Loss of Balance
___Dizziness
___Loss of Hearing
___Pain in Ears
___Ringing in Ears

NECK
___Neck Pain
___Neck Stiffness
___Muscle Spasms
___Grinding Sounds
___Popping Sounds
Neck Pain with movement:
___Forward
___Backward
___Turn to Right
___Turn to Left
___Bend to Right
___Bend to Left

UPPER EXTREMITIES
___Shoulder Pain
___Tension in Shoulders
___Rotator Cuff Problems
___Difficult To Raise Arm
___To Shoulder Level
___Above Shoulder Level
___Pain in Upper Arm
___Elbow Pain
___Pain in Forearm
___Pain in Hands
___Pain in Fingers
___Numbness or Tingling in Arm
___Numbness or Tingling in Hands/Fingers
___Cold Hands
___Fingers go to Sleep
___Swollen Finger Joints
___Sore Finger Joints
___Arthritis in Fingers
___Loss of Grip Strength

UPPER BACK
___Upper Back Pain
___Pain between Shoulder Blades
___Pain from Front to Back

LOWER BACK
___Low Back Pain
___Muscle Spasms
___Herniated Disk
Aggravated By:
___Working
___Lifting
___Standing
___Sitting
___Bending
___Coughing/Sneezing
___Lying Down
___Walking
Other_____
_____
Relieved By_____
_____

LOWER EXTREMITIES
___Pain in Buttocks
___Pain in Hip
___Leg Pain
___Knee Pain
___Leg Cramps
___Cramps in Feet
___Numbness or Tingling in Legs
___Numbness or Tingling in Feet/Toes
___Ankle Pain
___Foot Pain
___Swollen Ankles
___Swollen Feet
___Cold Feet

CHEST:
___Chest Pain
___Shortness of Breath
___Pain Around Ribs
___Breast Pain
___Dimpled Breast
___Irregular Heartbeat

ABDOMEN:
___Upset Stomach
___Nausea
___Gas
___Constipation
___Diarrhea
___Hemorrhoids
Problem Foods_____
_____
_____

WOMEN ONLY
Are You Pregnant?_____
___Menstrual Pain/Cramps
___Irregular Cycle
___Discharge
Birth Control (Type)_____
_____
Hysterectomy (when)_____
Cancer/Type:_____
Menopause_____
Tumors_____
Abortions_____

MEN ONLY
___Frequent Urination
___Difficulty in Starting
___Night Urination
___Prostate Problems
Cancer/Type:_____

GENERAL
___Nervousness
___Irritable
___Depressed
___Fatigue
___Frequent Colds/Flu
Weight Loss____pounds
Weight Gain____pounds

HEALTH HABITS
Tobacco:
Cigarettes # / day_____
Cigars # / day_____
Alcohol:
Wine #glasses/d or wk____
Beer #glasses/d or wk_____
Liquor #ounces/d or wk___
Caffeine:
Coffee #6 oz cups/d_____
Tea #6 oz cups/d_____
Soda cans/d_____
Other sources_____
Water: # glasses/d_____

EXERCISE
___5-7 days per week
___3-4 days per week
___1-2 days per week
___45 minutes or more
___30-45 minutes
___Less than 30 minutes
___Walk
___Run/Jog
___Weight lift
___Swim
___Bike
Other_____

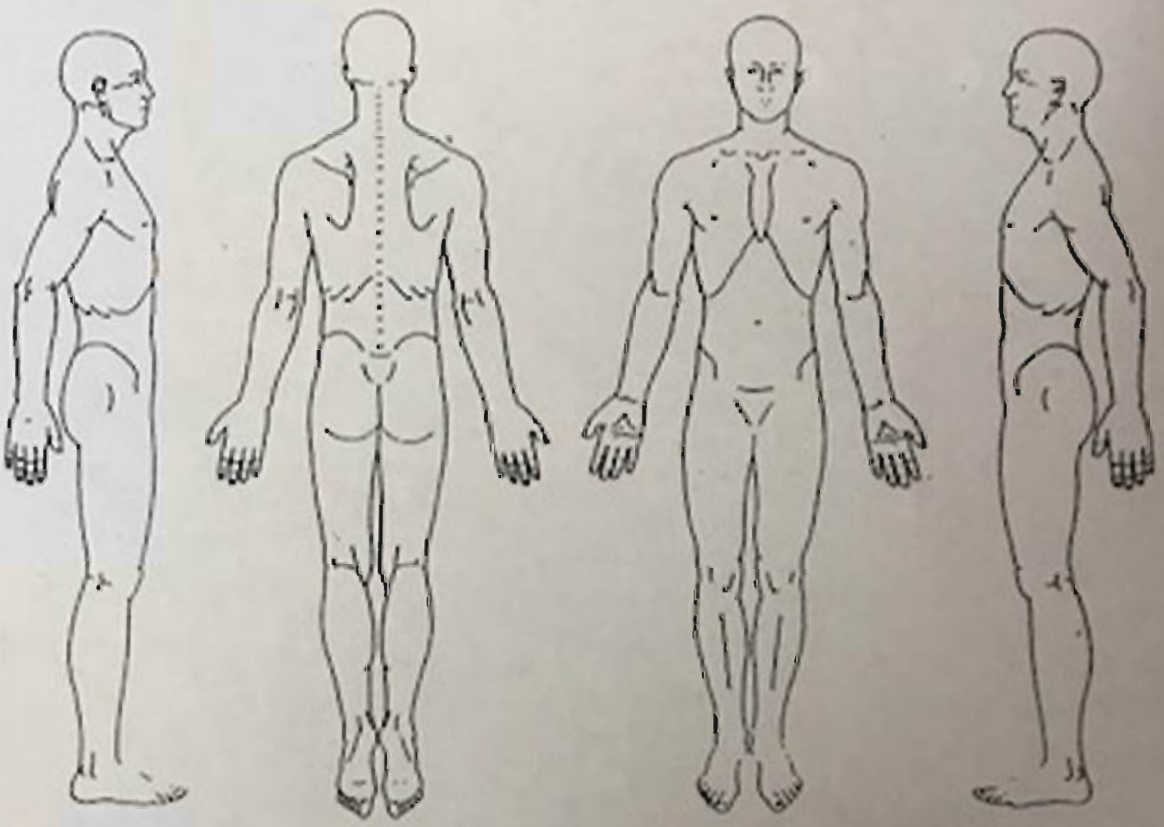
DAILY PATIENT RECORD

Name_____ Date____/____/____ Time_____

Please use the following key to accurately mark the areas in which you feel the described sensations. Use the appropriate symbols and include all affected areas.

Dull NNN Stabbing/Cutting /// /// /// Burning XXX

Numb = = = Tingling (Pins & Needles) ::::::: Cramping SSS



Please place one mark on the line below to indicate your present pain level:

No pain |———————————————————————| Worst pain ever

Using the scale of 0-100, with 0 = no pain and 100 = worst possible pain, please write the number indicating your present pain level in the box at the right:

Please indicate any changes in your condition in this space:

Patient Signature_____

NEMCEK CHIROPRACTIC CENTER

OFFICE POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. The following is our Office Policy, which we require that you read and sign prior to treatment.

OFFICE HOURS: The office is open **Monday, Wednesday** and **Friday** from 9:00-12:00 and 2:00-6:00, **Tuesday** and **Thursday** 3:00-7:00, **Saturdays** by appointment. The office is *closed* on **Sundays.** New Patients and Emergencies are accepted daily.

MISSED APPOINTMENTS: Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. This fee will be your responsibility, not your insurance company's. Please help us serve you better by keeping your scheduled appointments.

PAYMENT: Full payment is due at the end of each appointment for cash patients. Insurance patients are expected to pay their portion of the bill on a regular basis. We accept cash, checks and credit cards (VISA, MASTERCARD, AMEX and DISCOVER). Non-covered supplies such as: ice packs, pillows, braces, vitamins etc. need to be paid for at the time of purchase.

All services rendered to you are charged directly to you, and you are personally responsible for payment. Our office will prepare any forms and reports to assist you, but your insurance policy is a contract between you and the insurance company, and it is in your best interest to be aware of your coverage. Your insurance company may not cover some, or perhaps all of the services provided. Therefore, we will wait until payment is made from your insurance company to determine your portion of the payment that is due.

By signing this Office Policy you have agreed to the terms and understand our policies. If you have any further questions, please feel free to ask them at any time.

_____

Please print your name

_____

Please sign your name

_____

Today's date

CONSENT AND RELEASE

I authorize the release of information to family physicians and employer.

I authorize the release of information to insurance companies.

I authorize the taking of photographs and x-rays to be used for treatment purposes.

FEMALES:
I verify, to the best of my knowledge, I am not pregnant and give permission to perform diagnostic x-rays. I have been advised that x-rays can be hazardous to an unborn child. First day of last menstrual period_____.

I consent to the performance of other diagnostic and therapeutic procedures for treatment purposes.

Patient Signature (or guardian, if minor)_____ Date_____