Patient Information

Date:_____

Name_____How did you hear about us?_____

SSN_____ Date of Birth_____ Age_____ Gender M or F

Address_____City_____State_____Zip_____Marital Status_____

Cell Phone:_____Home Phone_____# Children_____

Is it OK to text you? Y or N e-mail _____

Occupation_____Employer:_____

Spouse's Name:_____ Parent's Names (if you are under 18)_____

Do you have Health Insurance or Medicare? □Yes □No Company_____

Name of Insured Person_____Their Birth Date_____

If you have insurance, please present your card(s) to the office manager for processing.

Describe your symptoms:_____

_____

When did your symptoms begin?_____ **Have you had similar symptoms in the past**? □Yes □No

How did your symptoms begin? □Work Injury □Auto Accident □Other(describe):_____

Progression (circle): Improving Not-Improving Worsening **||What makes it worse?**_____

Describe: Sharp Shooting Achy Burning Numb Tingling **||What makes it better?**_____

How severe are the symptoms on a scale of 1-10?(circle) NONE -1 2 3 4 5 6 7 8 9 10-WORST

In general, how would you rate your current overall health? Excellent Very good Good Fair Poor

Has it affected your ability to work or do housework? □Yes □No How many days off from work/housework?_____

What are your favorite hobbies or activities?_____**Currently Affected?** □Yes □No

Have you seen a Chiropractor in the Past? □Yes □No If Yes, when was your most recent visit?_____

Why did you see the Chiropractor?_____Doctor's Name?_____

What frequency was prescribed for your ongoing maintenance care?_____

Why are you changing chiropractors?_____

Check any of the following that you are currently using/wearing: □ Heel lift □Arch Supports □Back brace

Who is your Primary Medical Physician? _____Clinic name/Phone_____

When was your last set of medical blood or urine tests?_____

Why did you come into our clinic and what are your expectations of us?_____

_____

Any other health concerns?

_____

_____

_____

_____

HEALTH HISTORY - Please read through the list and check the box next to each condition that applies to you **even if you think it may not be important to the chiropractor.**

Last known: Height_____ Weight_____ Blood Pressure _____/_____(don't know)
What is your exercise routine? _____How do you de-stress?_____
Are you pregnant? □Yes □No **How is your diet**?_____

Musculoskeletal - General
Now Past
□ □ Degenerative arthritis
□ □ Rheumatoid arthritis or Gout
□ □ Compression fracture
□ □ Osteomyelitis
□ □ Osteoporosis

Musculoskeletal Spine
□ □ Poor Posture
□ □ Disc injury
□ □ Neck problem
□ □ Mid-back problem
□ □ Low back problem
□ □ Scoliosis
□ □ Ankylosing spondylitis
□ □ Difficulty swallowing because of neck pain
□ □ Pain or electric shocks in arms or legs on moving neck

Musculoskeletal Extremity
□ □ Hip or sacroiliac problem L R
□ □ Leg, Knee, ankle or foot L R problem
□ □ Shoulder problem L R
□ □ Arm,elbow,hand problem L R
□ □ Rib or chest pain

Nervous System
□ □ Headaches or migraines
□ □ Tingling or numbness of arms, legs, hands or feet
□ □ Pinched nerve or sciatica
□ □ Poor balance
□ □ Depression or Anxiety
□ □ Difficulty dealing with stress
□ □ Dizziness or vertigo
□ □ Learning disorder or hyperactivity (ADD/ADHD)
□ □ Seizures/Epilepsy
□ □ Recent progressive muscle weakness or shaking
□ □ Numbness of inner thighs/groin

EENT
□ □ Jaw, TMJ or mouth problem
□ □ Visual problems
□ □ Ear problems, infections or ringing
□ □ Chronic sinus problems
□ □ Face pain

GI/GU/Endocrine
□ □ Abdominal pain
□ □ Constipation/Diarrhea
□ □ Heartburn/Acid Reflux/Ulcers
□ □ Uncontrolled Bladder or Bowel
□ □ Inflammatory bowel disease
□ □ Liver or gallbladder problems
□ □ Menstrual problems or PMS
□ □ Menopause symptoms
□ □ Difficulty getting/staying pregnant/other

Cardio-Pulmonary
Now Past
□ □ Pacemaker or implanted device
□ □ Breathing trouble or Asthma
□ □ High blood pressure
□ □ History of stroke or aneurysm

Medication-Related Issues
□ □ Medication dependence
□ □ Drug or Vaccination reaction
□ □ Current drug side-effects
□ □ Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc.
□ □ 3 or more months of steroid medications or intravenous drugs (past or present)

Injuries and General Constitution
□ □ Car crash/whiplash injuries
□ □ Work injuries
□ □ Ergonomic stress at work
□ □ Sports injuries
□ □ Smoking habit: How much/day?_____
□ □ Drug or alcohol dependence or recovering
□ □ Psoriasis or psoriatic arthritis
□ □ Unexplained weight loss
□ □ Sleeping trouble
□ □ Get sick a lot/poor immune function
□ □ Fibromyalgia / Chronic fatigue
□ □ Tuberculosis, Hepatitis or HIV
□ □ Cancer or Tumor
□ □ Allergies:_____
□ □ Recent fever over 102°F
□ □ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
□ □ Constant pain that doesn't improve by changing positions or by lying down
□ □ **OTHER HEALTH PROBLEM NOT LISTED**:_____
_____
_____

FAMILY HISTORY
(circle any that apply)
Back problems / Back/neck surgery / Heart problems / Diabetes / Rheumatoid arthritis / high blood pressure/ Cancer / Other:
_____
_____

LIST ALL SURGERIES / PROCEDURES
_____
_____
_____
_____

LIST ALL MEDICATIONS/VITAMINS/ SUPPLEMENTS/HERBALS:
_____
_____
_____
_____
_____
_____

NAME:_____

Consent to Examination and Treatment
I hereby request and consent to the performance of chiropractic examination, adjustments and other chiropractic procedures on me (or the patient named below, for whom I am legally responsible) by Dr. Julie Page and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backdrop for Dr. Julie Page. I understand and I am informed that, in the practice of chiropractic that there are some risks to examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

Our Privacy Policy
The office of Dr. Julie Page is committed to upholding the security and confidentiality of personal information that you provide to us. We take our responsibility of safeguarding your information very seriously. We do not share or sell patient information with anyone outside our office without your written consent. This policy covers information including personal, financial, or health information about a consumer or customer relationship. I hereby authorize that my records of evaluation and treatment with the office of Dr. Julie Page may be forwarded to referring physicians, specialists, or therapists who are also involved in my healthcare.

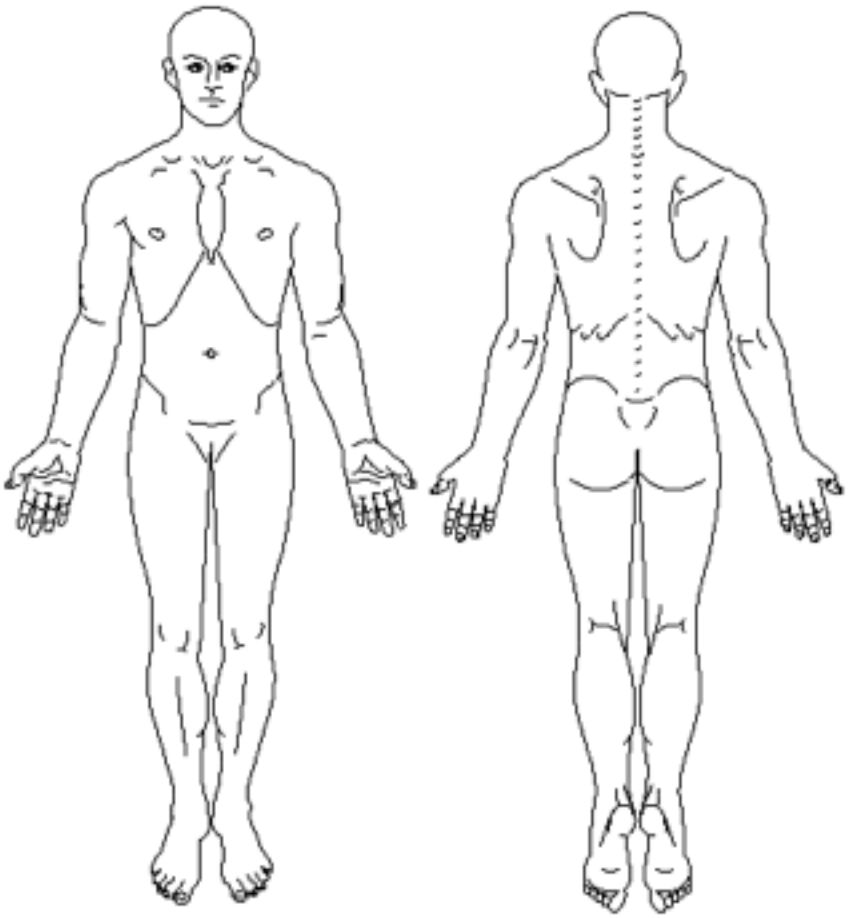
By signing below, I have read, or have had read to me, the above consent to evaluation and treatment statement, that I am aware of the privacy policy, and that I certify that my confidential medical information above is correct to the best of my knowledge.

Patient or Guardian's Signature_____ **Date** _____

Name:_____ Date:_____

PAIN DRAWING

SHADE IN WITH A PEN ALL AREAS YOU HAVE PAIN.
(Don't forget to include the head or areas of lesser pain).
Use small x's to show any areas of numbness or tingling



Please mark on the line, the pain level that most accurately represents your pain for **<u>each</u>** body area:

		0	1	2	3	4	5	6	7	8	9	10	
Right now:	No pain	|											Unbearable
Average pain:	No pain	|											Unbearable
At best & worst:	No pain	|											Unbearable