Ray Chiropractic Patient Information

Date: _____

Name: _____ Nick Name: _____

Sex: _____ Marital Status: _____Date of Birth: _____ Age:_____

Nationality: American Indian or Alaskan Native ____ Asian ____ Black or African American ____ White ____

Native Hawaiian or Other Pacific Islander___ Decline to Specify _____ Other _____

E-mail:_____Social Security #:_____

Address:_____City:_____ State:_____ Zip Code:_____

Home #: _____ Cell Phone #:_____Cell Phone Carrier: _____

May we text you for appointment reminders? Yes _____ No _____

Employer:_____ Work #:_____ Fax:_____

Occupation: Job Description _____Work Schedule _____

Emergency Contact Name:_____Phone #:_____

Are you currently enlisted in the military? Yes / No If so, what branch:_____

Is your visit due to an accident? Yes / No Work Auto Other_____

Has this injury been reported? Yes / No To: Employer____ Auto Carrier_____ Other_____

Have you retained an attorney? Yes / No Name & Phone #:_____

Are we filing with your health insurance company? Yes_____ No:_____

Name of Insurance Company.: _____

Who referred you to our office?_____Thank Them!

Please give your insurance cards and driver's license to front desk to make copies for our records.

Name: _____ Date: _____

Have you ever received chiropractic care? Yes / No If yes, when? _____

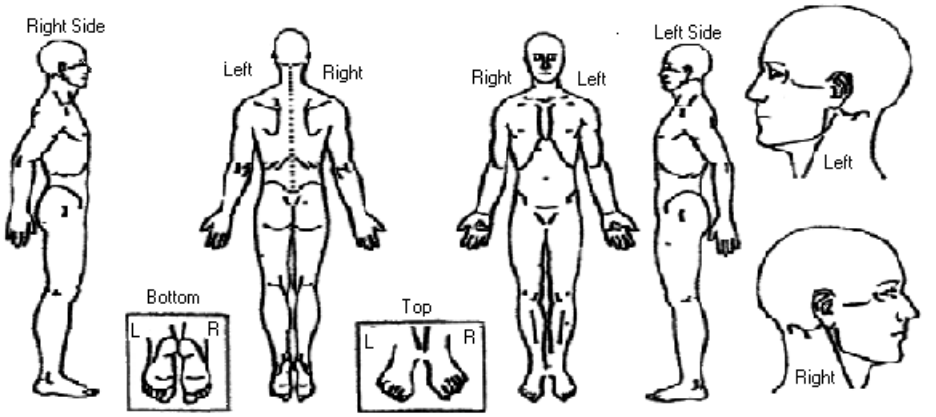
1. Primary reason for seeking chiropractic care and or Chief Complaint _____

_____

Secondary reason _____

Third Reason etc._____

3. Where does it hurt? Please mark and/or shade in your problem areas with the following key: Quality of Pain
X-sharp **D**-dull **A**-ache B- Burning S- Sore St- Stiff N-Numb T- Tingling R- Radiating Other describe in space Examples: deep, throbbing, migraine, visual disturbances, dizziness, light sensitive, stabbing, shooting _____ _____



Acute Gradual Recurrent Chronic ?

Intensity: 0 (no pain) to **10** (worst pain imaginable) **1 2 3 4 5 6 7 8 9 10** (circle it or show range)

When did symptoms begin: (approximate date) _____

How did your symptoms begin: (describe) _____

What settings hurt: (describe) _____

How frequent do you have the problem?_____ How long does it last? _____

How has it limited/changed your daily activities (work, sleep, relations, sit/stand/car etc.)_____

_____

Are you currently or have you been treated for this condition before? Yes _____ No _____

When/By Whom/Outcome _____

Current X-rays/CT Scan/MRI: Yes _____ No _____

Office/Facility Taken: _____

Additional Information – Use space below

_____

_____

_____

_____

_____

Name: _____ Date: _____

Please place a ☑ check mark next to P A S T conditions. ***Please circle the C U R R E N T* conditions.**

General
Weight loss
Weight gain
Change in Sleep Pattern
Change in activity capacity

Neurological & Psychiatric
Anxiety
Headaches
Depression
Meningitis
Paralysis
Seizure
Stroke
Tingling or numbness
Tremors
Memory loss
Fainting spells, dizziness
Head injuries
Blackouts or near blackouts
Change in sensation anywhere on your body
Localized weakness
Localized numbness

Ears, Eyes, Nose & Throat
Hay fever
Glaucoma
Polyps
Allergies
Cataracts
Goiter
Hoarseness
Double vision
Gum problems
Eye problems
Ear infections
Glasses / Contacts
Hearing loss
Ear discharge / pain
Frequent nosebleeds
Ringing in your ears
Sinus infections
Swollen Glands

Notes

_____

_____

_____

_____

Cardiovascular
Angina
Chest Pain
Murmurs
Leg cramps
Ankle swelling
Awakening at night with shortness of breath and getting out of bed
Dizziness when rising up
Heart Attacks
Heart Failure
High or low blood pressure
Irregular heart rate
Purple fingers or lips
Leg pain that resolves w/rest
Heart palpitations
Varicose veins

Respiratory
Pleurisy
Wheezing
Asthma
Breathlessness when lying flat
Prolonged cough
Emphysema
Shortness of breath
Tuberculosis
Pneumonia
Frequent lung infections
Bronchitis
Coughing up blood

Skin
Abscess
Dandruff
Acne
Oily skin
Boils
Rashes
Hives
Dry skin
Lumps
Psoriasis
Jaundice
Athlete's foot
Excessive body odor
Excessive sweating
Fungal infections
Nail problems
Moles / irregular
Moles / change/ new

Kidneys & Urinary Tract
Blood in urine
Brown urine
Dribbling after urination
Painful urination
Excessive thirst
Incontinence/Bladder control
Frequent urination (day/night)
Urinary hesitancy
Weak flow
Frequent bladder infections
Kidney disease
Kidney stones

Endocrine
Diabetes
Sickle Cell Anemia
Abnormal body hair
Changes in skin texture
Cold intolerance
Heat intolerance
History of borderline diabetes
Increased loss of hair
Rheumatism
Thyroid disease

Male & Female
Painful sexual intercourse
Loss of sexual interest
Unprotected sex
Groin itching
Sexually transmitted diseases

Males Only
Hernia
Sterility
Bloody ejaculation
Inability to complete intercourse
Lump on testicle
Penile discharge
Premature ejaculation
Problems maintaining erection
Prostate disease
Sores or warts on Penis
Testicular pain
Testicular swelling

Females Only
Bleeding after intercourse
Complications w/ pregnancy
Bleeding between cycles
Endometriosis
Pelvic Inflammatory Disease
Postmenopausal Symptons

Females Only (cont.)
D&C
Hot Flashes
Hernia
Fibroids
PMS
Abnormal Pap smear
Heavy bleeding in cycle
Discharge from breast
Ovarian cysts
Vaginal discharge
Vaginal dryness
Vaginal warts

Musculoskeletal
Arthritis
Anemia
Back Pain
Bursitis
Gout
Joint aches
Neck pain
Tendonitis
Abnormal blood work
Blood clot in legs/lungs
Bone marrow biopsy
Easy bleeding
Joint swelling
Morning stiffness
Muscle aches
Easy bruising

Gastrointestinal
Diarrhea
Gallstones
Reflux
Vomiting
Ulcers
Heartburn
Hepatitis
Indigestion
Abdominal pain
Anal fissures
Black tarry stools
Vomiting blood
Constipation
Nausea
Problems swallowing
Hiatal Hernia
Intestinal obstruction
Liver disease
Hemorrhoids
Red blood after bowel movement

Name: _____ Date: _____

SOCIAL HISTORY:
Smoker: Never Smoked _____
Current Every Day Smoker _____
Current Some Days Smoke _____
Former Smoker _____
Tobacco Use: Yes / No
Alcohol: Yes / No Amount: Daily/Weekly/Monthly _____
Caffeine: Yes / No Amount: Daily/Weekly/Monthly _____
Exercise: Yes / No Amount: Daily/Weekly/Monthly _____

HISTORY: Have ***YOU*** *or* ***FAMILY MEMBERS*** *ever been diagnosed with any of the following;*

	Cancer	***Diabetes***	***Heart Disease***	***Heart Failure***	***High Blood Pressure***	***Kidney Disease***	***Stroke***	***Other***
Self	_____	_____	_____	_____	_____	_____	_____	_____
Mother	___	_____	_____	_____	_____	_____	_____	_____
Father	___	_____	_____	_____	_____	_____	_____	_____
Sibling	___	_____	_____	_____	_____	_____	_____	_____

If yes to any above, please explain:
_____
_____
_____

ALLERGIES:
Drugs/List if any: _____ Reaction: _____
Seasonal/List if any: _____ Reaction: _____
Skin/List if any: _____ Reaction: _____
Foods/List if any: _____ Reaction: _____

MEDICATIONS:
Name: _____ Strength _____ Dosage _____ Frequency _____ Reason _____
Name: _____ Strength _____ Dosage _____ Frequency _____ Reason _____
Name: _____ Strength _____ Dosage _____ Frequency _____ Reason _____
Name: _____ Strength _____ Dosage _____ Frequency _____ Reason _____
Name: _____ Strength _____ Dosage _____ Frequency _____ Reason _____

HOSPITALIZATIONS:
When_____ Reason _____
When_____ Reason _____

SURGERIES:
Date_____ Type of Surgery_____
Date_____ Type of Surgery_____
Date_____ Type of Surgery_____

ACCIDENTS/INJURIES: (i.e. car, sports, work falls, other)
Pease give details: _____
_____

BROKEN BONES/FRACTURES:
Pease give details: _____
_____

Name: _____ Date: _____

ILLNESSES, INFECTIONS, or DISEASE (Acquired, Inherited, At Birth, HIV, Arthritis)
Pease give details:_____
_____

CHILDHOLD DISEASES:
Have you had all childhood disease? Yes ____ No _____
Have you received all immunizations? Yes___ No ____
If no to any above, please explain:
_____
_____
_____
_____

Have you received flu immunization: Yes ___ No___ **If yes, approximate date:** _____

Are you Pregnant? Yes ___ **No** _____ if yes, how many weeks_____
Date of last menstrual cycle? _____
How many pregnancies and outcomes? _____
Last Meal?_____
When was your last general physical from your family physician? Approx Date_____

EDUCATION:

Level of Education: High School Some College College Graduate Post Graduate Studies

Recreational activities / Hobbies_____

To the best of my knowledge, all of this information is true and correct.

The patient is responsible for payment of all professional services rendered regardless of insurance coverage. It is customary to pay for services when received unless other arrangements have been made **in advance**. I understand that I am financially responsible to Ray Chiropractic to charges not covered by my insurance and will be billed accordingly. If applicable, I also understand that if I do not follow the requirement(s) as outlined in my managed care benefit plan (referrals, authorizations, etc.), I will be financially responsible for these charges. Upon default I am subject to all reasonable costs of collection and/or attorney fees.

I hereby authorize the release of information to insurance carriers concerning my illness and treatment, and I hereby assign to the physician all payments for medical services rendered to me or to my dependents.

Patient, Parent or Guardian Signature:_____ Provider Initials:___