Patient Information

Today's Date:____/____/_____

Patient Name:_____

Patient Address:_____

_____

Patient Social Security #:_____

Sex: □ Male □ Female

Age:_____ Date of Birth:_____/_____/_____

Marital Status: □ Single □ Married □ Widowed

□ Separated □ Divorced

Spouse's Name:_____

Whom may we thank for referring you? Phonebook Website
Doctor_____ Friend_____

Who is your primary care physician?_____

Patient Phone: (___)_____-_____ Home

(___)_____-_____ Cell

(___)_____-_____ Work

Would you like text reminders for follow-up appointments? Yes/No

If yes, what's your cell carrier?_____

Email:_____

Would you like our monthly email newsletter? Yes/No

In Case of Emergency, Contact:

Name:_____

Relationship:_____

Phone: (_____)_____-_____

Individual/Family Health Insurance Information

Insurance Company (Circle One): Excellus RMSCO Cigna MVP

Aetna United Health Medicare Other _____

Subscriber ID#:_____

Subscriber's Name:_____

Relationship to Patient:_____

Specialist Co-pay_____ or Deductible Amount_____

Patient Name _____ Date _____

Medication

Please list all **prescription** and **over the counter medications** you are currently taking:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Please list all **nutritional supplements** you are taking:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Do you have any Allergies? (Circle One) None Seasonal Chemical Medication

_____

_____

Have you ever had surgery? Yes/No

Date: (Year) _____ Type of surgery:_____

Date: (Year) _____ Type of surgery:_____

Date: (Year) _____ Type of surgery:_____

Social History (Circle all that apply)

Do you smoke? Never Daily Quit

Do you drink alcohol? None Casual Moderate Heavy

Do you drink caffeine? None 1-2/day 3-6/day 6+/day

Do you use recreational drugs? None Recreational User Addiction

Do you exercise? Never Weekly Daily

Work Status: Student Employed Unemployed Retired Homemaker

Occupation: _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with and assign directly to Apple Country Chiropractic P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Apple Country Chiropractic P.C. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible party signature_____ Date:_____

Patient Name _____ Date _____

Patient History Questionnaire

Pain Diagram

1. Please list your current complaints in the order of their severity with the chief complaint being the most severe complaint.

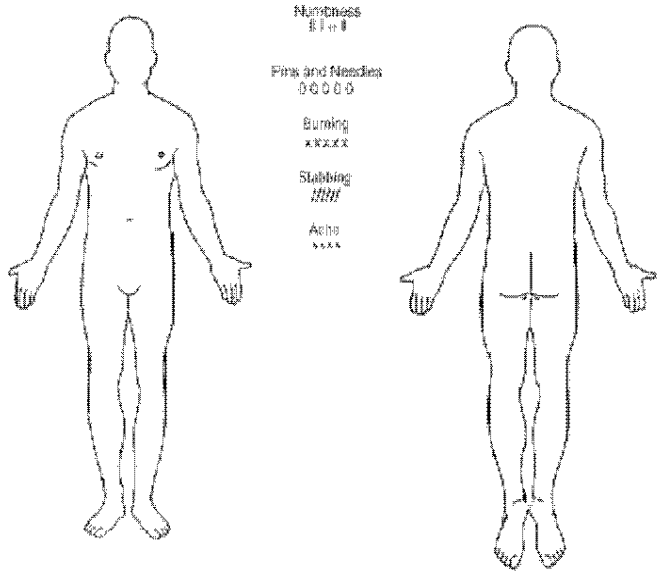
Chief complaint _____
Complaint 2 _____
Complaint 3 _____

2. Please mark with an X on the body form where the pain is worst now.

3. Please circle the appropriate number below indicating how severe your chief complaint pain is now.

No Pain ▼ Worst Pain Possible ▼

0 1 2 3 4 5 6 7 8 9 10



1. What type of pain are you experiencing?
- □ Achy □ Burning □ Sharp
- □ numb □ Shooting □ Stiffness
- □ Other _____

2. Are you currently experiencing any of these symptoms in your arms or legs?
- □ Cramping □ Twitching
- □ Numbness □ Tingling
- □ Muscle weakness □ Other

3. How often do you feel the pain?
- □ Constant □ Episodic □ Occasional
- □ Frequent □ Intermittent

4. How did the pain start?
- □ Suddenly □ Gradually □ Pulling
- □ Lifting □ Twisting □ Bending
- □ Fall □ Auto accident □ Sports
- □ Injured at Work □ No apparent cause
- □ Other

5. What makes the pain better?
- □ Heat □ Cold □ Standing
- □ Aspirin □ Lying Down □ Sitting
- □ Stretching □ Nothing
- □ Chiropractic □ Muscle relaxant pills
- □ Advil/Ibuprofen □ Other

6. What activities make the pain worse?
- □ Exercise □ Sitting □ Walking
- □ Standing □ Coughing □ Sneezing
- □ Bending forward □ Bending backward
- □ Other _____

7. What time of day are your symptoms the worst?
- □ Morning □ Evening
- □ While sleeping □ All day

8. Are you currently experiencing any of the following difficulties?
- □ Difficulty Sleeping
- □ Bowel dysfunction
- □ Bladder dysfunction
- □ Sexual dysfunction

9. When did your symptoms begin?

Doctor's Notes

_____
_____
_____
_____
_____
_____

Patient Name _____ Date _____