SPINAL CORRECTION CENTERS

BASIC INFORMATION DATE: ___/___/____

FIRST NAME: _____ MI: ___ LAST NAME: _____

SS#: _____ DATE OF BIRTH: ____/_____/____ AGE: _____ GENDER: M F

MARITAL STATUS: S M W D Domestic Partner PARTNER'S NAME: _____

SPOUSE'S OCCUPATION: _____ NUMBER OF CHILDREN/AGES: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: (H): _____ (W): _____ (C): _____ EMAIL: _____

PRIMARY PHYSICIAN: _____ PHONE NUMBER: _____

DATE OF LAST VISIT TO PRIMARY CARE PHYSICIAN (MO/YR): _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

HAVE YOU EVER RECEIVED CHIROPRACTIC CARE BEFORE? Y N

IF YES, PLEASE LIST PRIOR TREATMENTS: _____

CURRENT EMPLOYMENT INFORMATION

OCCUPATION: _____ COMPANY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INSURANCE INFORMATION

PLEASE ENSURE A COPY OF YOUR PHOTO ID & INSURANCE CARD ARE ON FILE WITH OUR OFFICE.

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD

---ONLY COMPLETE THIS SECTION IF THE PATIENT IS DIFFERENT FROM THE INSURED---

NAME OF INSURED: _____ DATE OF BIRTH: ___/___/___

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SS#: _____ PHONE NUMBERS: (H) _____ (W) _____

INSURED'S EMPLOYER: _____

WORK ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Spinal Correction Centers. Iunderstand and agree to allow Spinal Correction Centers to use my Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. I understand that I am responsible for all costs of healthcare regardless of insurance coverage. It is myresponsibility to pay any deductible, co-insurance, and/or any other balances not paid by my medical insurance carrier. Co-paysare due at the time of each visit. I will provide Spinal Correction Centers with 24-hour notice if I cannot make my scheduled appointment. If I fail to do so, I understand a fee of $25 may be applied to my account and I am responsible to pay this fee within 30 days of its application.

PATIENT SIGNATURE: _____ DATE: ____/____/____

GUARDIAN'S SIGNATURE AUTHORIZING CARE: _____ DATE: ____/____/____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP TO PATIENT: _____

PHONE NUMBERS: (H) _____ (W) _____ (C) _____

PATIENT NAME: _____ DATE: _____

REASON FOR OFFICE VISIT

WHY ARE YOU HERE TODAY? _____

DOES THE PAIN/PROBLEM RADIATE TO ANY OTHER PART OF THE BODY? Y N

IF SO, PLEASE SPECIFY: _____

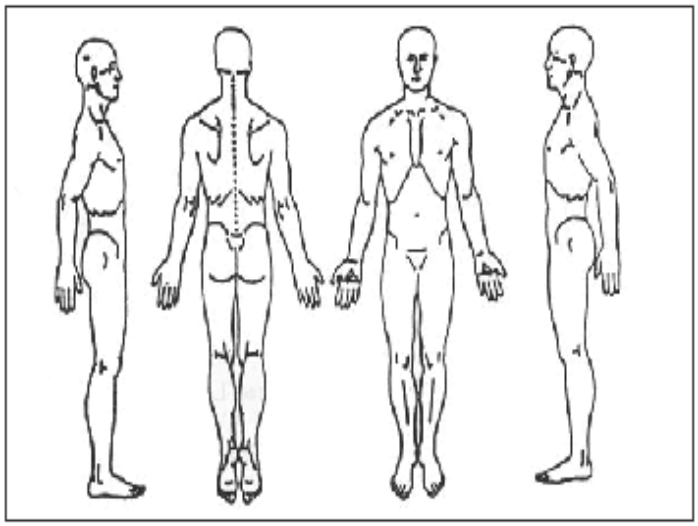
WHEN DID IT START? _____

WHAT CAUSED IT TO START? _____

WORK RELATED? Y N AUTO ACCIDENT?Y N OTHER (SPECIFY): _____

MARK THE AREAS ON THE DIAGRAM WITH THE APPROPRIATE SENSATIONS YOU FEEL. INCLUDE ALL AFFECTED AREAS.

NUMBNESS	PINS & NEEDLES	BURNING	ACHING	SHARP	DULL
++++++++++	00000000000000	XXXXXXX	**********	///////////	--------



PLEASE CIRCLE YOUR LEVEL OF PAIN BELOW
(1=MINIMAL PAIN; 10=WORST PAIN IMAGINABLE)

PAIN CURRENTLY
1 2 3 4 5 6 7 8 9 10

PAIN ITS WORST
1 2 3 4 5 6 7 8 9 10

PAIN TYPICALLY
1 2 3 4 5 6 7 8 9 10

DOCTOR ONLY:

DID IT BEGIN: GRADUALLY SUDDENLY

EXPLAIN: _____

HAS YOUR PROBLEM BEEN GETTING: BETTER WORSE SAME

IS YOUR CONDITION: INTERMITTENT CONSTANT

WHAT MAKES YOUR SYMPTOMS: BETTER: _____

WORSE: _____

HOME REMEDIES USED: _____

WHAT DOCTORS HAVE YOU SEEN FOR THIS? _____

WHAT TESTS HAVE BEEN DONE FOR THIS CONDITION? PLEASE LIST RESULTS OF ANY TEST PERFORMED, IFKNOWN. _____

HAVE YOU HAD THIS CONDITION BEFORE? Y N

HAVE YOU BEEN UNABLE TO WORK AS A
RESULTOF YOUR CURRENT CONDITION? Y N

DOCTOR ONLY: _____

_____

_____

_____

_____

_____

PATIENT NAME: _____ DATE: _____

REVIEW OF SYSTEMS

PLEASE WRITE "C" IF YOU CURRENTLY HAVE THE CONDITION OR "P" IF YOU PREVIOUSLY HAD THE CONDITION.

GENERAL
___Diabetes
___Cancer
___Headaches lasting days
___Difficulty speaking
___Fainting/Dizziness
___Fatigue
___Fever
___Night sweats
___Sleep loss
___Weight loss/gain
___Double vision
___Pain in neck/jaw/face
___Dizziness/Vertigo
___Stroke
___Tremors
___Anxiety/Depression

EYES, EARS, NOSE, THROAT
___Asthma
___Colds
___Sore throat
___Deafness
___Dental decay
___Earache/noises
___Ear discharge
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose bleeds
___Failing vision
___Far sighted
___Near sighted
___Gum Trouble
___Hoarseness
___Nasal obstruction
___Tonsil Stones

MUSCULOSKELETAL
___Arthritis
___Bursitis
___Foot issues
___Hand issues
___Low back pain
___Hernia
___Neck pain/stiffness
___Shoulder blade pain
___Poor posture
___ Sciatica

Pain/Numbness in:
___ Arm
___ Shoulder
___ Elbow
___ Wrist
___ Hand
___ Tailbone
___ Hip
___ Knee
___ Feet
___ Ankle
___ Foot

GENITO-URINARY
___Bedwetting
___Blood in urine
___Frequent urination
___Inability to control bladder
___Kidney infection or stones
___Painful urination
___Prostate trouble
___Pus in urine
___Painful menstruation
___Hot flashes
___Irregular cycle
___Lumps in breasts

CARDIOVASCULAR
___Hardening of arteries
___High blood pressure
___Low blood pressure
___Pain over heart
___Poor circulation
___Rapid/Slow heart beat
___ Heart disease
___Swelling of ankles

RESPIRATORY
___Chest pain
___Chronic cough
___Difficult breathing
___Spitting up blood
___Spitting up phlegm
___Wheezing

GASTROINTESTINAL
___Belching or gas
___Colitis
___Colon trouble
___Constipation
___Diarrhea
___Difficult digestion
___Distention of abdomen
___Excessive hunger
___Heartburn / reflux
___Gall bladder trouble
___Hemorrhoids
___Intestinal worms
___Jaundice
___Liver trouble
___Nausea
___Pain over stomach
___Poor appetite
___Vomiting
___Vomiting blood

PERSONAL HABITS

PLEASE ANSWER HONESTLY. *ALL INFORMATION IS CONFIDENTIAL.* PLEASE RATE YOUR ANSWER ON A SCALE OF 1-5, WITH 1 BEINGNO/NEVER AND 5 BEING YES/OFTEN.

	1	2	3	4	5	ELABORATE
EXERCISE REGULARLY						
RECREATIONAL DRUGS						
DRINK ALCOHOL						
SMOKE CIGARETTES						
CHEW TOBACCO						
EXPERIENCE HIGH STRESS						
OTHER						

PLEASE LIST ALL MEDICATIONS AND DOSES (INCLUDE VITAMINS, HERBS, AND OVER-THE-COUNTER MEDICATIONS)

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

PATIENT NAME: _____ DATE: _____

PAST MEDICAL HISTORY

HOSPITALIZATIONS / SURGERIES (PLEASE LIST PROCEDURES, DATES AND LOCATIONS):_____

_____

_____

PREVIOUS INJURIES (SPRAINS, FRACTURES, AUTO OR OTHER ACCIDENTS, ETC.): _____

_____

_____

ALLERGIES (MEDICATION, FOOD, OTHER SUBSTANCE): PLEASE LIST AND DESCRIBE THE REACTION YOU HAD:_____

_____

HAVE YOU TRAVELED OUT OF THE COUNTRY? Y N IF YES, WHEN/WHERE:_____

WOMEN ONLY:

MENSTRUAL PERIODS: AGE ONSET: _____ REGULAR? YES NO

DATE LAST PERIOD BEGAN: ____/____/____ AVERAGE CYCLE LENGTH: _____

ARE YOU CURRENTLY TAKING BIRTH CONTROL PILLS? YES NO DURATION: _____

ARE YOU CURRENTLY PREGNANT? YES NO DUE DATE: ____/_____/_____

DO YOU EXPERIENCE:

IRREGULARITY? YES NO

MENSTRUAL PAIN? YES NO

AGE AT ONSET OF MENOPAUSE (IF APPLICABLE): _____ DATE OF LAST PAP/PELVIC EXAM? ____/____/____

HAVE YOU EVER HAD ABNORMAL PAP SMEAR RESULTS? YES NO

NUMBER OF CHILDREN: BORN ALIVE:____ CESAREAN:_____ PREMATURE:_____ MISCARRIAGES: _____

DESCRIBE PREGNANCY COMPLICATIONS (IF APPLICABLE): _____

MEN ONLY:

DATE OF LAST PROSTATE EXAM: ___/___/___

DIFFICULTY URINATING: YES NO

FREQUENT URINATION: YES NO

HAVE YOU EVER BEEN DIAGNOSED WITH

BENIGN PROSTATIC HYPERTROPHY (BPH)? YES NO

LAST DATE YOU HAD YOUR PSA LEVEL TESTED? (MO/YEAR): ____/____ RESULTS OF PSA TESTING? _____

DOCTOR ONLY: _____

_____

_____

_____

FAMILY HISTORY

PLEASE MARK AN "X" IN THE APPROPRIATE BOX CORRESPONDING TO EACH ILLNESS KNOWN IN YOUR FAMILY.

	MOTHER	FATHER	SIBLINGS	MATERNAL AUNTS/UNCLES	PATERNAL AUNTS/UNCLES	MATERNAL GRANDPARENTS	MATERNAL GRANDPARENTS
ARTHRITIS							
CANCER							
DIABETES							
HEART DISEASE							
STROKE							
KIDNEY DISEASE							
NEURO DISEASE							
THYROID DISEASE							

PATIENT NAME: _____ DATE: _____

LEAVE BLANK FOR DOCTOR REMARKS: