FirstChoice Chiropractic & Rehabilitation, pc

PATIENT REGISTRATION

(To be filled out by patient)

First Name: _____ Last Name: _____

Sex: M / F Birthdate: _____ Age: _____ Social Security Number: _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____ Work Phone: ( ) _____-_____

Email Address: _____

Employer: _____ Occupation: _____

Employer Address: _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified: _____ Phone: _____

I authorize FirstChoice Chiropractic to: ❒text ❒call ❒email me appointment reminders and/or other messages: ❒Yes ❒No

HEALTH INSURANCE INFORMATION

Is patient covered by additional Health Insurance? ❒Yes ❒No

Insurance Company: _____ Phone: ( ) _____-_____

Address: _____

Subscriber Name: Last: _____ First: _____

ID Number: _____ Group Number: _____

Social Security Number: _____-_____-_____ Birthdate: _____

Relationship to Patient: _____

Address (if different from above: _____ City: _____ State: _____ Zip: _____

PERMISSION TO DISPLAY

By my signature below, I hereby give permission for my photo and testimonial to be displayed in the clinic of First Choice Chiropractic and Rehabilitation as well as the internet (our website, You Tube, Facebook and the internet in general). I understand that only my first name will be used.

_____ _____

Signature Printed Name

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (name of insurance company(ies) and assign directly to FirstChoice Chiropractic & Rehabilitation, pc, 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 authorize the use of my signature on all insurance submissions. FirstChoice Chiropractic & Rehabilitation, pc, may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____/_____/_____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Printed Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

FirstChoice Chiropractic & Rehabilitation, pc
Patient Intake
(To be filled out by patient)

Patient Name: _____ **Date:** _____/_____/_____

D/Birth: ____/_____/_____ **D/Injury:** _____/_____/_____ **Type: MVA WC MM CA PI**

Location of your Pain: ❒Headache ❒Neck ❒Shoulders ❒Upper back ❒Low Back ❒Arms ❒ Legs
❒ Other: _____
_____
_____

Describe your pain: ❒Sharp ❒ Aching ❒ Dull ❒Stabbing ❒Burning ❒Throbbing ❒Pulsing
❒Other: _____

How often is your pain present: ❒Constant ❒Intermittent ❒Occasional
❒Other: _____

Do you have ❒ numbness in your arms: ❒ right arm ❒ left arm ❒ both
❒ tingling in your legs: ❒ right leg ❒left leg ❒ both
❒ radiating pain
❒ weakness Other: _____

When did your pain start: ❒Immediately ❒Few hours later ❒Next day ❒Few days later
❒Other: _____

Have you been experiencing pain in any of these areas before this injury? ❒Yes ❒No
If yes, explain: _____
_____
_____

Are you sleeping ok? ❒Yes ❒No If no, why? _____

Since the Accident are you feeling: ❒Better ❒Worse ❒Same

Do you feel better in the morning or evening? ❒Morning ❒Evening ❒Same

What position makes the pain better if any: ❒Laying Down ❒Sitting ❒ Changing positions often
❒Standing ❒Nothing makes the pain better

What position makes the pain worse if any: ❒Laying down ❒Sitting ❒Standing ❒Bending ❒Lifting
❒Walking ❒Reaching ❒Kneeling ❒Squatting ❒Grasping ❒Staying in prolonged positions

What have you tried at home to help: ❒Massage ❒Laying down ❒Hot bath/shower ❒Ice ❒Heat
❒Pain Medication ❒Pain Cream ❒Rest Other: _____

Did it help? ❒Yes ❒No ❒A little

Patient Signature: _____ Date: _____/_____/_____

Doctor Signature: _____ Date: _____/_____/_____

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PATIENT RECORD INTAKE

(To be filled out by patient)

Name: _____ Date: _____/_____/_____

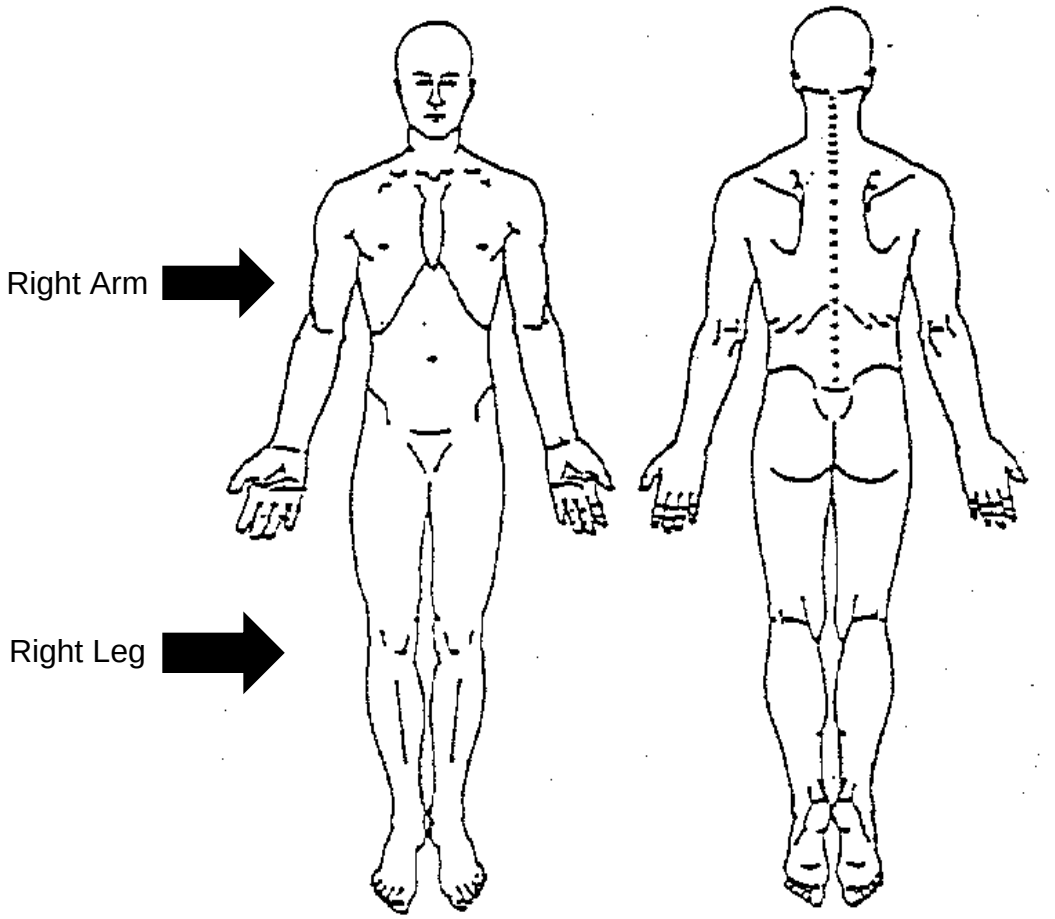
Date of Birth: _____/_____/_____ Date of Injury: _____/_____/_____

Type: MVA / WC / CA / MM / PI

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

Dull Ache: 1 Stabbing/Cutting: 2 Burning: 3 Numbness: 4 Weakness: 5 Cramping: 6

Tingling (Pins & Needles): 7 Soreness: 8 Tightness: 9 Tense: 10 Spasms: 11



Patients Signature: _____ Date: _____/_____/_____

Doctor's Signature: _____

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Visual Analog Scale (VAS) Intake

(To be filled out by patient)

Name: _____ Date: _____/_____/_____

Date of Birth: _____/_____/_____ Date of Injury: _____/_____/_____

Type: MVA / WC / PI / MM / CA

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

Cervical (neck): |----------|

Headaches: |----------|

Thoracic (mid back): |----------|

Lumbar (low back): |----------|

Right/Left Shoulder |----------|

Right/Left Elbow |----------|

Right/Left Wrist |----------|

Right/Left Knee |----------|

Right/Left Ankle |----------|

All Other areas:

_____ |----------|

_____ |----------|

_____ |----------|

(The patient was instructed to how mark this VAS form and it was described that the far left side of the line was "no pain" and the far right side was "extreme pain" bad enough that they would have to go to the hospital.)

Patient Signature: _____ Date: _____/_____/_____

Doctor Signature: _____

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HEALTH HISTORY - CONFIDENTIAL

(To be filled out by patient)

Patient Name: _____ Date: _____/_____/_____

Age: _____ Birthdate: _____/_____/_____ Date of last physical examination: _____/_____/_____

What is your reason for visit today? _____

SYMPTOMS: (check all symptoms you currently have or have had in the past year)

CONSTITUTIONAL

- ❒ Chills
- ❒ Depression
- ❒ Dizziness
- ❒ Fainting
- ❒ Fever
- ❒ Forgetfulness
- ❒ Headache
- ❒ Loss of sleep
- ❒ Loss of weight
- ❒ Nervousness
- ❒ Numbness
- ❒ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ❒ Arms
- ❒ Back
- ❒ Feet
- ❒ Hands
- ❒ Hips
- ❒ Legs
- ❒ Neck
- ❒ Shoulders

GENITO-URINARY

- ❒ Blood in urine
- ❒ Frequent urination
- ❒ Lack of bladder control
- ❒ Painful urination

ENDOCRINE

- ❒ Loss of hair
- ❒ Heat/Cold Intolerance
- ❒ Changes in appetite
- ❒ Excessive thirst and urination

PSYCHIATRIC

- ❒ Anxiety / Depression
- ❒ Mood Swings
- ❒ Difficulty sleeping

GASTROINTESTINAL

- ❒ Appetite poor
- ❒ Bloating
- ❒ Bowel changes
- ❒ Constipation
- ❒ Diarrhea
- ❒ Excessive hunger
- ❒ Excessive thirst
- ❒ Gas
- ❒ Hemorrhoids
- ❒ Indigestion
- ❒ Nausea
- ❒ Rectal bleeding
- ❒ Stomach pain
- ❒ Vomiting
- ❒ Vomiting blood

CARDIOVASCULAR

- ❒ Chest pain
- ❒ High blood pressure
- ❒ Irregular heart beat
- ❒ Low blood pressure
- ❒ Poor circulation
- ❒ Rapid heart beat
- ❒ Swelling of ankles
- ❒ Varicose veins

RESPIRATORY

- ❒ Cough
- ❒ Coughing Blood
- ❒ Difficulty Breathing
- ❒ Wheezing
- ❒ Night Sweats
- ❒ Chills

HEMATOLOGY/LYMPATIC

- ❒ Easy Bruising
- ❒ Frequent gums bleeding
- ❒ Enlarged glands

EYE, EAR, NOSE, THROAT

- ❒ Bleeding gums
- ❒ Blurred vision
- ❒ Crossed eyes
- ❒ Difficulty swallowing
- ❒ Double vision
- ❒ Earache
- ❒ Ear discharge
- ❒ Hay fever
- ❒ Hoarseness
- ❒ Loss of hearing
- ❒ Nosebleeds
- ❒ Persistent cough
- ❒ Ringing in ears
- ❒ Sinus problems
- ❒ Vision - flashes
- ❒ Vision - halos

SKIN

- ❒ Bruise easily
- ❒ Hives
- ❒ Itching
- ❒ Change in moles
- ❒ Rash
- ❒ Scars
- ❒ Sore that won't heal

ALLERGIC/IMMUNOLOGICAL

- ❒ Hives / Eczema
- ❒ Seasonal allergies
- ❒ Frequent skin infection
- ❒ Frequent Runny nose
- ❒ Hypersensitivity to insect bites

NEUROLOGICAL

- ❒ Loss of strength/weakness
- ❒ Numbness/pins & tingling
- ❒ Tremors
- ❒ Memory Loss
- ❒ Headaches
- ❒ Seizures

MEN ONLY

- ❒ Breast lump
- ❒ Erection difficulties
- ❒ Lump in testicles
- ❒ Penis discharge
- ❒ Sore on penis
- ❒ Other

WOMEN ONLY

- ❒ Abnormal pap smear
- ❒ Bleeding between periods
- ❒ Breast lump
- ❒ Extreme menstrual pain
- ❒ Hot flashes
- ❒ Nipple discharge
- ❒ Painful intercourse
- ❒ Vaginal discharge
- ❒ Other

Date of last menstrual period: _____

Date of last pap smear: _____

Have you had a mammogram?
( )Yes ( )No

Are you pregnant?
( )Yes ( )No ( )Unsure

Are you trying?
( )Yes ( )No

Number of children _____

CONDITIONS: (check all symptoms you currently have or have had in the past year)

- ❒ AIDS
- ❒ Alcoholism
- ❒ Anemia
- ❒ Anorexia
- ❒ Appendicitis
- ❒ Arthritis
- ❒ Chemical dependency
- ❒ Chicken pox
- ❒ Diabetes
- ❒ Emphysema
- ❒ Epilepsy
- ❒ Glaucoma
- ❒ High cholesterol
- ❒ HIV positive
- ❒ Kidney disease
- ❒ Liver disease
- ❒ Measles
- ❒ Migraine headaches
- ❒ Prostate problem
- ❒ Psychiatric care
- ❒ Rheumatic fever
- ❒ Scarlet fever
- ❒ Stroke
- ❒ Suicide attempt

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❒ Asthma	❒ Goiter	❒ Miscarriage	❒ Thyroid problems
❒ Bleeding disorders	❒ Gonorrhea	❒ Mononucleosis	❒ Tonsillitis
❒ Breast lump	❒ Gout	❒ Multiple sclerosis	❒ Tuberculosis
❒ Bronchitis	❒ Heart disease	❒ Mumps	❒ Typhoid fever
❒ Bulimia	❒ Hepatitis	❒ Pacemaker	❒ Ulcers
❒ Cancer	❒ Hernia	❒ Pneumonia	❒ Vaginal infections
❒ Cataracts	❒ Herpes	❒ Polio	❒ Venereal disease

MEDICATIONS: List medications you are currently taking:

_____
_____
_____

ALLERGIES:

_____
_____
_____

FAMILY HISTORY: Fill in health information about your immediate family: *(To be filled out by patient)*

Relation	Age	State of Health	Age at Death	Cause of Death	Check if your blood relatives had any of the following: Disease:	Relationship to you:
Father					❒ Arthritis, Gout	
Mother					❒ Asthma, Hay Fever	
Brothers					❒ Cancer	
					❒ Chemical Dependency	
					❒ Diabetes	
					❒ Heart Disease, Stroke	
Sisters					❒ High Blood Pressure	
					❒ Kidney Disease	
					❒ Tuberculosis	
					❒ Other	

HOSPITALIZATIONS
Year: Hospital: Reason for Hospitalization:

_____
_____
_____

PREGNANCIES
Year of Birth: Sex: Complications, if any:

_____
_____
_____

Have you ever received a blood transfusion? ( )Yes ( )No
If yes, please give approximate dates: _____

Serious Illness: Date: Outcome:

_____
_____
_____
_____

HEALTH HABITS Mark which you use and how much:
_____ Caffeine _____
_____ Tobacco _____
_____ Other _____

OCCUPATIONAL Mark if your work exposes you to:
_____ Stress _____ Hazardous Substances
_____ Heavy Lifting ____Other: _____

Social History - ADULT:
1. Drink alcohol: ❒ Yes ❒ No If yes, how much: ❒ Occasionally ❒ Frequently ❒ Daily
2. What activities do you do that are now difficult? ❒ Sports ❒ Housework ❒ Caring for children ❒ Driving ❒ Walking ❒ Sitting ❒ Running ❒ Other: _____

MINOR: 1. What grade is the patient in: _____
2. Activities normally engaged in at school: PE ____ Sports ____ Other _____
3. Are these activities difficult to perform since injury? ❒ Yes ❒ No If yes, what: _____
4. Has patient missed school: ❒ Yes ❒ No If yes, how many days: _____
5. If minor, who is present with the child? Mother / Father / Other: _____

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____/_____/_____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient