



PATIENT INFORMATION FORM

Please fill information out in detail for this is important to your case

First name, M.I., Last Name, Nickname, Address, Social Security #, City, State, Zip, Age, Sex, Birthdate, Marital Status, Number of Children, Home Phone, Cell, Work Phone, Employer, Occupation, Referred by, Person Responsible for this Account, Closest Relative, Address/Phone #

What is your main complaint?

Is this condition due to an: A) auto accident B) work injury C) other accident D) unknown cause

Date symptoms appeared

Are symptoms: A) improving B) getting worse C) about the same D) intermittent (come & go)

Have you had these symptoms before? Yes / No If so, when,

Circle any activities that aggravate your condition: A) standing B) walking C) sitting D) lying E) bending F) lifting G) twisting H) coughing I) Other

Other doctors seen for this condition A) MD B) Chiropractor C) Osteopath D) Dentist F) Podiatrist Dr(s). Name Date Consulted Diagnosis

Have you had surgery? (Y / N) When and What?

Have you had plastic surgery/augmentations? When and What?

Do you have any significant diseases? (ie. Cancer, Diabetes, etc.)

Have you had any broken bones? (Y / N) When and What?

Have you been in any accidents? (Y / N) When and Type?

Are you taking any medications? (Y / N) What?

Do you have insurance? (Y / N) Insurance Company

I understand and agree that the health and accident insurance policies are an arrangement between my insurance carrier and myself, not between the insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete usual and customary reports and forms to assist in collecting from my insurance company. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

Patient's/Guardian's Signature Date



CIRCLE ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY:

- | | | |
|------------------------------|---------------------|----------------------|
| Headaches | Digestive Disorder | Stroke |
| Migraines | Frequent Urination | Menstrual Cramping |
| Head Seems Heavy | Nausea | Diabetes |
| Loss of Memory | Constipation | Ringing in Ears |
| Dizziness | Diarrhea | Swollen Joints |
| Fainting | Extreme Fatigue | Difficulty Lifting |
| Tremors | Shortness of Breath | Difficulty Standing |
| Palpitations | Asthma | Difficulty Walking |
| Neck Pain/Stiffness | Pain Radiating to: | Difficulty Sitting |
| Neck Motion Restricted | Right Arm | Difficulty Bending |
| Upper Back Pain/Stiffness | Left Arm | Sinus Congestion |
| Lower Back Pain/Stiffness | Both arms | Sinus Drip |
| Pins and Needles in Arms | Right Leg | Sinus Pressure |
| Pins and Needles in Legs | Left Leg | Insomnia |
| Numbness in Fingers and Arms | Both Legs | Eye Strain |
| Numbness in Legs | Hips | Pain Behind Eyes |
| Chest Pain | Shoulders | High Blood Pressure |
| Cancer _____ | Poor Posture | Seizures |
| Heart Problems | Cold Hands/Feet | Equilibrium Problems |
| Depression | Varicose Veins | Other _____ |

Consent for Chiropractic Care of a Minor:

I hereby authorize the Doctor of ADIO Chiropractic Center to administer care to my child.

Child's Name _____

Signed (parent or guardian) _____

Office Representative _____

Fees are due and payable at the time that the examination, x-rays and adjustments are received, unless other arrangements are made in advance. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes they cannot be released directly to the patient. However, they may be released to another physician with the properly signed releases and must be returned to this office within 14 days of release.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand ADIO Chiropractic Center, LLC will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount to be paid directly to ADIO Chiropractic Center, LLC will be credited to my account upon receipt.

However, I clearly understand and agree that I am responsible for payment.

Patient's Signature

Date

Guardian's Signature Authorizing Care for Minor

Date

In case of emergency, please notify: _____

Name of nearest relative/friend not living with you

Relationship

(_____) _____
Phone

DATE: _____

ACCT: _____

PATIENT: _____

PATIENT HISTORY

1. What is your **main complaint**? _____
2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

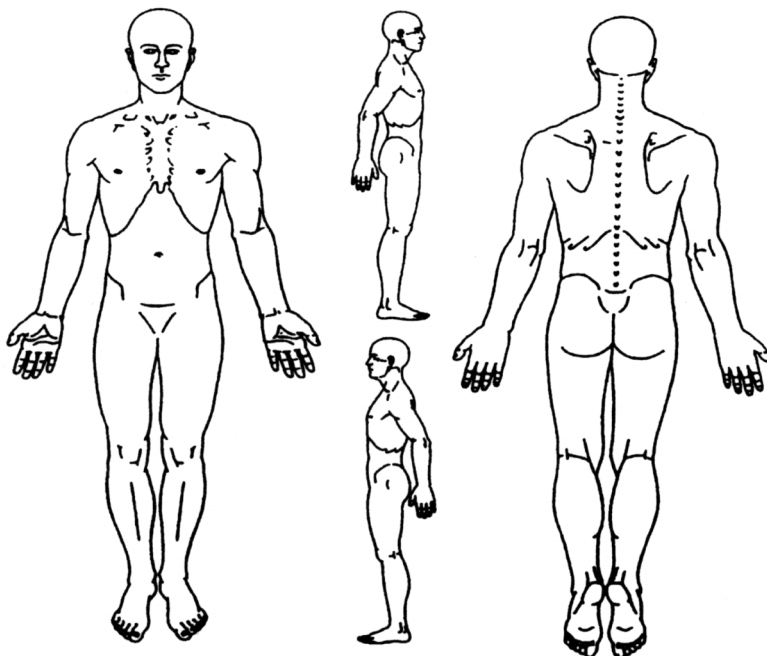
None	Slight		Mild		Moderate		Severe		
1	2	3	4	5	6	7	8	9	10

3. On the scale below please **circle** the **percentage of time** you experience your **main complaint**:

Occasional			Intermittent			Frequent			Constant		
0	10	20	30	40	50	60	70	80	90	100	%

4. How **long** have you been experiencing your **main complaint**? _____
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

- personal care _____
- lifting _____
- reading _____
- concentrating _____
- work _____
- driving _____
- sleeping _____
- recreation _____
- walking _____
- sitting _____
- standing _____
- social life _____

6. When do you notice it most? AM PM
How long does it last? _____ Mins _____ Hrs
7. What makes it feel better? _____
8. What makes it feel worse? _____
9. Have you ever had this problem in the past? Yes No
10. I have been hospitalized been treated by another chiropractor
 been treated by another specialty provider never received care for this problem.
11. Have you lost time from work because of it? Yes No
Dates? _____ to _____
12. Are you Pregnant? Yes No
13. What was the first day of your last menstrual cycle? _____
14. Number of pregnancies? _____ Miscarriages? _____

Signature: _____

Date: ___ / ___ / ___