SUNRICE
FAMILY + SPORT
CHIROPRACTIC LLC

Confidential Health Information

Please allow our staff to photocopy your driver's license and insurance details. All information is confidential. If you need assistance, please ask. Thank You.

Dr. Larissa Rice DC
717 Commercial St.
Atchison, KS 66002
Phone & Fax: (913) 367-1665

Date: _____

Last Name: _____ **First Name:** _____ **Middle Name (Initial):** _____

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

Phone: _____ **Cell:** _____ **E-Mail:** _____

Best way to contact you? O Home O Cell O Work O E-mail **Birthdate:** _____

O **Male** O **Female** **Marital Status:** O Single O Married O Divorced O Widowed O Separated

Spouse's Name: _____ **Children & Ages:** _____

How did you find us? O Referral O Flyer O Newspaper O Health Fair O Website O Other _____

Whom may we thank for referring you? _____

EMPLOYER INFORMATION

Occupation: _____ **Your Employer:** _____

Employer Address: _____ **Work Phone:** _____

MEDICAL INFORMATION

Primary Care Physician: _____ **Clinic Name:** _____

Address: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **May we contact him/her?** O Yes O No

List all medications/supplements you are currently taking or have taken (copy can be made at front desk).

_____

_____

List all medication allergies, if any, and the reactions. _____

_____

Have you had imaging (X-Ray, MRI, CT, etc.) for your current complaint? O Yes O No

If yes, what date? _____ **Where were they taken?** _____

Have you seen a chiropractor before? O Yes O No **If yes, when and with whom?** _____

Any accidents or other injuries (car, sports, etc.) experienced in the past? _____

_____

_____

PLEASE FILL OUT ENTIRE FORM.

ANY AREAS LEFT UNANSWERED MAY RESULT IN DENIED CLAIMS.

_____
Patient Name (Last, First)

Mark the area of your symptoms on the figure below using the following symbols:

Aching – O

Burning - /

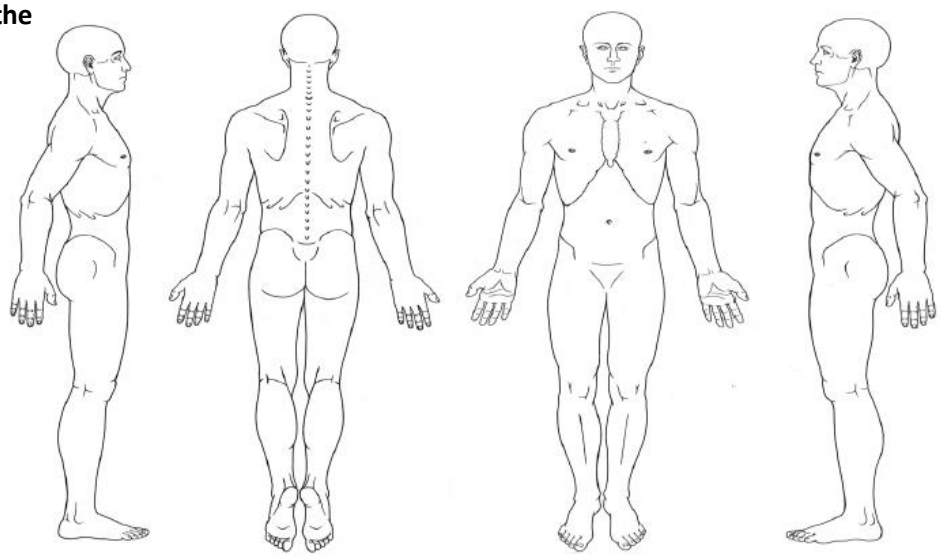
Numbness - *

Sharp - #

Stabbing - x

Throbbing - ^

Tingling - •



Right Back Front Left

Primary complaint: _____

What activity caused the complaint? (Ex. working, yardwork, bending etc.) _____

What day did you first notice the complaint? _____

What time of day do you normally notice the pain? O Waking Up O Morning O Afternoon O Evening O Night O All Day

Does the pain travel from one location to another? O Yes O No **If yes, where to where?** _____

Rate the pain as it is right now, 0-10 with 0 being no pain and 10 being the worst pain: _____

Rate the pain at its worst, 0-10: _____

What helps relieve the pain?

O Movement O Lying Down O Walking O Over-the-counter Medications
O Sitting O Chiropractic O Resting O Prescription Medications
O Heating Pad O Ice Pack O Massage O Other: _____

What aggravates the pain?

O Bending O Standing O Sitting O Sleeping O Getting out of car
O Twisting O Walking O Resting O Working O Rising from chair/bed
O Lifting O Pulling/Pushing O Cough/Sneeze O Putting on shoes/socks
O Daily Activities O Other: _____

Any prior treatment for this current complaint?

O MD O Physical Therapy O Medications O Massage O Cortisone Shots O Other_____

Additional complaint: _____

What do you believe caused the complaint? _____

When did you first notice the complaint? _____

What helps relieve the pain?

O Movement O Lying Down O Walking O Over-the-counter Medications
O Sitting O Chiropractic O Resting O Prescription Medications
O Heating Pad O Ice Pack O Other: _____

What aggravates the pain?

O Bending O Standing O Sitting O Sleeping O Getting Out of Car
O Twisting O Walking O Resting O Working O Rising from chair/bed
O Lifting O Pulling/Pushing O Cough/Sneeze O Putting on shoes/socks
O Daily Activities O Other: _____

_____
Patient Name (Last, First)

Review of Symptoms (Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please write a **"P"** for anything you have had in the **"PAST"** and an **"X"** for anything you currently **HAVE**.)

General
____Anxiety
____Chills/Sweats
____Depression
____Dizziness
____Fainting
____Fatigue
____Fever
____Headaches
____Mental Illness
____Seizures
____Tremors
____Weight Gain
____Weight Loss

Integumentary
____Acne
____Hair loss
____Rash
____Irregular Moles

Eye/Ear/Nose/Throat
____Eye Pain/Problems
____Blurred Vision
____Loss of smell
____Loss of taste
____Sore Throat
____Hoarseness
____Mouth/Gum Problems
____Sinus Infection
____Tonsillitis
____Hearing loss
____Ear Pain/Problems
____Ear Ringing

Respiratory
____Asthma
____Apnea
____Hay Fever
____Chronic Cough
____Difficulty Breathing

Cardiovascular
____High Blood Pressure
____Low Blood Pressure
____High Cholesterol
____Chest Pain
____Poor Circulation
____Irregular Heart Beat
____Swelling of Hands
____Swelling of Feet
____Excessive Bruising
____Bleeding Disorders

Gastrointestinal
____Anorexia/Bulimia
____Constipation
____Diarrhea
____Indigestion
____Bloating
____Stomach Pains
____Food Sensitivities
____Nausea
____Poor Appetite
____Vomiting

Genitourinary
____Bladder Infection
____Inability to Control Bladder
____Infertility
____Bedwetting
____Irregular urination
____Blood in Urine
____Painful Urination
____Low Libido

Males Only:
____Prostate Trouble

Females Only:
____PMS symptoms
____Irregular Cycles
____Pregnant

Neurological
____Numbness
____Pins & Needles
____Weakness

Musculoskeletal
____Scoliosis

Problems with:
___Neck
___Back
___Shoulder
___Arms
___Elbows/Wrist
___Hands
___Hips
___Legs
___Knees
___Ankles/Feet
___Tailbone
___TMJ

Habits

	none	light	mod	heavy
Water	O	O	O	O
Exercise	O	O	O	O
Coffee	O	O	O	O
Salty Foods	O	O	O	O
Sugary Foods	O	O	O	O
Alcohol	O	O	O	O
Tobacco	O	O	O	O
Soft Drinks	O	O	O	O
Artificial Sweeteners	O	O	O	O

Hobbies: _____

_____

Ailments (Please write a **"P"** for anything you have had in the **"PAST"** and an **"X"** for anything you currently **HAVE**.)

___Alcoholism
___Allergies
___Anemia
___Appendicitis
___Arteriosclerosis
___Autoimmune Problems
___Bronchitis
___Cancer
___Chicken Pox
___Cold Sores
___Colitis/Crohn's
___Diabetes
O Type I
O Type II
___Eczema
___Emphysema
___Epilepsy
___Gall Bladder
___Goiter
___Gout
___Heart Disease
___Hepatitis
___Hernia
___Herniated Disc
___Herpes
___HIV/AIDS
___Influenza
___Kidney Problems
___Liver Troubles
___Malaria
___Measles
___Multiple Sclerosis
___Mumps
___Osteoporosis
___Parkinson's
___Pneumonia
___Polio
___Psoriasis
___Rheumatic Fever
___STD
___Stroke
___Tuberculosis
___Thyroid Disease
___Ulcers
___Whiplash
___Other_____

Operations Surgical interventions which may/may not have included hospitalization. Please darken circle and write date.

O Appendix Removal_____
O Bypass Surgery_____
O Cancer_____
O Cosmetic Surgery_____
O Spine_____
O Elective Surgery_____
O Eye Surgery_____
O Hysterectomy_____
O Pacemaker_____
O Tonsillectomy_____
O Vasectomy_____
O Joint Replacement_____
O Gall Bladder Removal_____
O Other_____
_____

Family History (If any blood relative has had any of the following conditions, please darken circle and indicate which relative(s).)

O Alcoholism_____
O Anemia_____
O Arteriosclerosis_____
O Arthritis_____
O Asthma_____
O Bleed easily_____
O Cancer_____
Type_____
O Diabetes_____
O Emphysema_____
O Epilepsy_____
O Glaucoma_____
O Heart Disease_____
O High Blood Pressure_____
O High Cholesterol_____
O Multiple Sclerosis_____
O Osteoporosis_____
O Stroke_____
O Thyroid Disease_____
O Other_____

Other health issues/concerns that our staff should be made aware of?

_____