Premier Spine Center

Thank you for choosing Premier Spine Center. Please complete this confidential patient form.

Patient Information

Date_____

Name _____ Date of Birth _____

Address _____ SSN _____

City _____ State _____ Zip _____ Gender: Male Female

Preferred Phone _____ Email _____

Emergency Contact _____ *Relationship* _____ *Phone* _____

Financial and Insurance Information

Name of party responsible for payment

_____

Insurance Carrier _____

Group #_____

Do you have health insurance? Yes No

Do you have a health savings account? Yes No

Are you eligible for Medicare (over age 65) Yes No

Member ID _____

Employment Information

Employer _____ Occupation _____

Business Address _____

Hours of computer use daily? _____ Right or Left Handed? _____ Hours worked each week?_____

Hours driving daily? _____ Describe a typical work day _____

Hours on your feet daily?

Who may we thank for referring you to our office? _____

Reason for Today's Visit

Please rank your health concerns and rate their severity (on a scale from 1-10, 10 being the worst). **Severity 1-10**

1

2

3

4

Please list conditions you have been diagnosed with or are currently being treated for — Treating Practitioner

_____ _____

_____ _____

_____ _____

Please list all fractures and dislocations and year _____

List all prior surgeries, hospitalizations and year _____

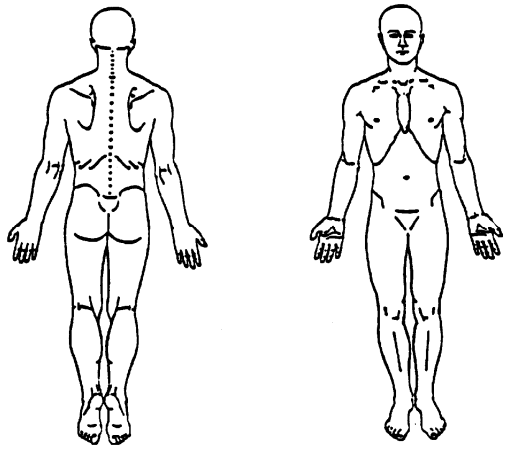
_____

Please list all allergies _____

Please list all medications and supplements you are currently taking _____

Chiropractic Intake

Current Symptoms
On the diagram to the right please mark **all** areas where you are currently having pain or other abnormal sensation. Please also indicate where your pain travels (if appropriate).



Please Rate Your Pain:
1. Circle the number that best describes your pain at its WORST in the past 24 hours. 1 2 3 4 5 6 7 8 9 10

2. Circle the number that best describes your pain at its LEAST in the past 24 hours. 1 2 3 4 5 6 7 8 9 10

3. Circle the number that best describes your pain on AVERAGE for the past WEEK. 1 2 3 4 5 6 7 8 9 10

Prior Chiropractic Care

Doctor _____ Location _____ Dates of Treatment _____

Why did you initiate care? _____

Why did you discontinue care? _____

Is today's visit due to a car accident? Yes No If yes, date of accident _____

Please list all car accidents by year

Lifestyle

Hours of sleep each night 0-2 3-5 6-8 9+ **Is your sleep** Restful Restless Hard to fall asleep Wake up often

Sports played Golf Snow Ski Water Ski Tennis Running Walking Martial Arts Volleyball Swimming Basketball Hockey Snowboard Cycling Fishing Hiking Other _____

Leisure Activities Reading Cooking Music TV Internet Other:

Do you smoke? Yes No **How much per day**? _____ **How much alcohol do you consume weekly**? _____

How much coffee/tea/caffeine do you consume daily? _____

Daily water intake: When I'm thirsty 2-4 glasses 5-8 glasses 9-12 glasses Constantly, I'm always thirsty

Women's Health

Date of last Pap Exam _____ Date of last menstrual period _____

Are you Pregnant? Yes No Number of Pregnancies _____ Number of vaginal births _____ Cesareans _____

Review of Systems Please check any symptom or condition that you either have **Now** or in the **Past**:

Now	Past		Now	Past		Now	Past		Now	Past		Now	Past	
		General			**Lungs**			**G-I System**			**Neurologic**			**Conditions (cont.)**
❒	❒	Weight loss	❒	❒	Difficulty breathing	❒	❒	Heartburn	❒	❒	Seizures/Epilepsy	❒	❒	Cataracts
❒	❒	Weight gain	❒	❒	Asthma	❒	❒	Indigestion	❒	❒	Stroke / TIA	❒	❒	Glaucoma
		Head	❒	❒	Persistent cough	❒	❒	Ulcers	❒	❒	Tingling	❒	❒	Tuberculosis
❒	❒	Headache	❒	❒	Coughing blood	❒	❒	Vomiting/Nausea	❒	❒	Numbness	❒	❒	Gallbladder Disease
❒	❒	Dizziness			**Vascular**	❒	❒	Abdominal pain	❒	❒	Weakness	❒	❒	Liver Disease
❒	❒	Head trauma	❒	❒	Chest pain	❒	❒	Persistent Diarrhea	❒	❒	Difficulty walking	❒	❒	Urinary infection
❒	❒	Fainting	❒	❒	Palpitations	❒	❒	Constipation	❒	❒	Poor coordination	❒	❒	Pneumonia
❒	❒	Concussion	❒	❒	Ankle swelling	❒	❒	Blood in Stool			**Muscle/Bone**	❒	❒	Diabetes
		Eyes	❒	❒	Cold feet/hands	❒	❒	Hemorrhoids	❒	❒	Joint Pain	❒	❒	Thyroid Condition
❒	❒	Changes in vision	❒	❒	Leg cramps			**G-U system**	❒	❒	Stiffness	❒	❒	
❒	❒	Light sensitivity	❒	❒	Calf pain	❒	❒	Difficulty urinating	❒	❒	Muscle ache	❒	❒	Anxiety
❒	❒	Spots in vision	❒	❒	Varicose veins	❒	❒	Pain urinating	❒	❒	Bone Pain	❒	❒	Depression
		Mouth	❒	❒	Low Blood pressure	❒	❒	Blood in urine				❒	❒	Multiple Sclerosis
❒	❒	Jaw pain	❒	❒	High Blood pressure	❒	❒	Incontinence			**Conditions**	❒	❒	Parkinson's' Disease
❒	❒	Bleeding Gums			**Skin**	❒	❒	Increase urination	❒	❒	Anemia	❒	❒	Gout
❒	❒	Dentures	❒	❒	Rash			**Nose**	❒	❒	Osteopenia	❒	❒	High Cholesterol
			❒	❒	Easy bruising	❒	❒	Nosebleeds	❒	❒	Osteoporosis	❒	❒	Cancer
			❒	❒	Itching/Peeling	❒	❒	Sinus problems	❒	❒	Arthritis			_____
			❒	❒	Changes in moles						_____			_____

Family History Please list if a parent or sibling has a history of the following

Cancer _____

Heart Disease _____

Hypertension _____

Diabetes_____

Auto-Immune Diseases _____

Epilepsy _____

Arthritis

Additional Information / Questions

Are there any specific questions about your condition or chiropractic that you want the doctor to address at today's visit in addition to a thorough history and physical exam?

_____

_____

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing inaccurate information can be harmful to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such chiropractic care to third party payers and/or other health practitioners. I authorize or request my insurance company to pay directly to Premier Spine Center insurance benefits that are otherwise payable to me. I understand that my chiropractic insurance carrier may cover only a portion of or not cover all of the services rendered.

I agree to be ultimately responsible for all fees for services rendered and that fees are payable when services are rendered.

X

Signature of Patient (or guardian if minor) **Date**