CONFIDENTIAL PATIENT DATA

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Today's date: **LAST 4 SS #:**

PATIENT INFORMATION

Patient's last name: First: Middle Initial:	Nickname:		Date of Birth:	Sex: ❑M ❑F
Street address:	Work Phone:	Home Phone:	Preferred Phone: ❑Home ❑Work ❑Cell	
Address Line 2:	Cell Phone:		Married__ Single__ Divorced___ Separated___ Other____	
City:	State:	Zip Code:	Email:	

Have you had Chiropractic Care? (circle) Yes No

Preferred Communication: (circle) Cellphone Home Phone Work Phone Email

I sleep on my: (circle) Back Side Stomach Toss & Turn

Exercise Level: (circle) None Light Moderate Heavy

Number of hours you sleep nightly. _____	Number of bottled waters you drink daily. _____

INSURANCE INFORMATION

Primary Insurance:	Insured ID:
Insured Name:	Group Number:
Patient is the ❑Spouse ❑Child ❑Self ❑_____ to the insured.	Ins. Date of Birth:
Secondary Insurance:	Insured ID:
	Group Number:

HIPPA- Health Information and Accountability Act
Release of Information Form
Armaly Chiropractic

Name:_____ Date of Birth: _____ /_____ /_____

Release of Information:

I authorize the release of information including the diagnosis, records, examinations rendered to me and claims information. This information may be released to (Please check all that apply):

___ Spouse-Name_____Phone:_____

___ Child(ren)-Name(s)_____Phone:_____

___ Other-Name_____Phone:_____

___ Information is not to be released to anyone other than for insurance purposes and when required by law.

This Release of information will remain in effect until terminated by me in writing

Messages:

Please call or text: ( ) my home ( ) my work ( ) my cell

If unable to reach me, (choose one):

( ) you may leave a detailed message

( ) please leave a message asking me to return your call

( ) Other: _____

The best time to reach me is_____

Email:

Most of our patients prefer for us to communicate with them via email. By providing your email address below, you give Armaly Chiropractic permission to email you appointment reminders, summaries, and other office announcements.

Email:_____

We may also mail seasonal /birthday cards to the listed address in your file

Signed:_____Date:____/_____/_____

Witness:_____Date:____/_____/_____

SYMPTOMS SURVEY

Explain your primary pain:

_____

_____

Rate Your Pain Scale:

No Pain ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 Sever

Circle type of pain?	Circle when it hurt worse:	Pain radiates into:	What caused your pain?
Sharp Dull Ache	Morning Afternoon	----------	----------
Burning Radiating	Evening During sleep	----------	----------
		----------	----------
		----------	----------

Circle what aggravates your pain?	Previous treatment?	How long have you had this pain?
Bending Lifting Laying down Sitting	----------	----------
Other ----------	----------	----------
	----------	----------
	----------	----------

What relieves your pain?	How does it affect your daily activities?
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Dr's Comments: _____

_____

For Doctor's use only:

Cervical Restricted W/Pain: Flexion – Extension - R. lat. Flexion - L. lat. Flexion – R – Rotation - L. Rotation

Lumbar Restricted W/Pain: Flexion – Extension - R. lat. Flexion - L. lat. Flexion - R. Rotation - L. Rotation

Muscle spasm with tenderness: Cervical: __Lt. __Rt. Thoracic: __Lt. __Rt. Lumbar: __Lt. __Rt.

Cervical compression test: __ Lt. __Rt.

Kemp test: __Lt. __Rt. Nachlas test: __Lt. __Rt. SLR: __Lt. __Rt.

Treatment Recommendation: __ Spinal Adjustment __ Soft Tissue Therapy __ Stretches __ Exercises

Goal: __ Pain control / Temporary pain relief. __ Recovery / Increase ability to perform daily activities.

Notes: _____

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