Scott Chiropractic and Wellness

PERSONAL INFORMATION

PLEASE PRINT

First Name:_________________ **M.I.**_____ **Last Name:**_________________ **Preferred Name:** _______________

Address: _________________________________ **City:** _______________ **State:** _____ **Zip:** _________

Birthdate: _____ / _____ / _____ **Age**______ **Gender:** ☐ Male ☐ Female **SSN:**___________ / _____ / _______

Primary Phone: _______________ **Cell Phone:** _______________ **Work Phone:** _______________

Home Email: _________________________________

Cell Phone Service (circle one): AT&T Sprint T-Mobile Verizon Other: __________

By providing my email address and cell phone number, I authorize my doctor to contact me via email/text with the email address and phone number provided.

Contact Method: (check one) ☐ Primary Phone ☐ Cell Phone ☐ Work Phone ☐ Home Email

Occupation: _______________________ **Employer:** _______________________________

Status: (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Name: ____

Race: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐Native American ☐.Other:__________ ☐ I choose not to specify

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I choose not to specify

Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Japanese ☐ Chinese ☐ German ☐ .Other _______ ☐ I choose not to specify

Emergency Contact: Name: ______________________ **Phone #:** ___________________ **Relationship:** ________

Family Physician Name: ___________________________ City: _____________________________

Phone Number: ______________________________

How were you referred to Scott Chiropractic? ☐ Patient __________________ ☐ Physician____________________

☐ Internet ☐ Newspaper ☐ Sign ☐ .Other ____

INSURANCE OR PRIVATE PAY INFORMATION

Type of Insurance: ☐ Private Ins. ☐ Medicare ☐ Auto Ins. ☐ Other______________________________

Primary Insurance Carrier: ________________________________ Phone: ____________________

Policy# _____________________ Group # ___________________

Name of Policy Holder: ________________________________ Relationship to Patient: ________________

Policy Holder's Birthdate: _______ / _____ / ______ Policy Holder's SSN: _______ / ___ / ______ Employer: ______________

Is patient covered by another insurance? ☐ Yes ☐ No

Secondary Insurance Carrier: ___________________________ Policy #: ______________________

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above-named insurance company(s) and assign directly to Scott Chiropractic all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above-named provider's office may use my health care information and may disclose such information to the above-named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

☐ **Private Pay/Cash:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered.

Name of person responsible for this account: ____

X ____ **Date:** ____________________

Signature of Patient, Parent or Legal Guardian (if minor)

REASON FOR VISIT

What is the reason for your visit today? ☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain ☐Other ________________

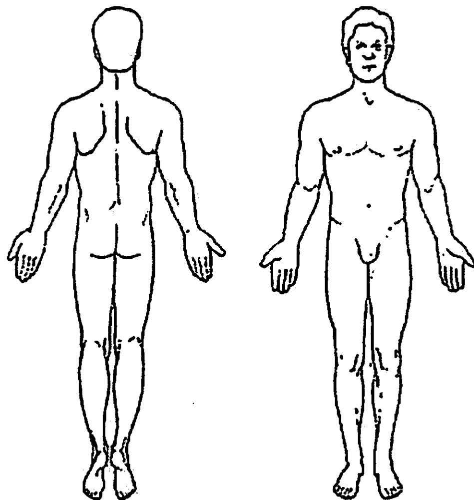
What caused this complaint(s)? ____

____

When did this complaint begin? ___/ _____/_____ **Is it getting worse?** ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Have you had this or similar complaint in the past? ☐ Yes ☐ No If "Yes", when? ________________

What does your complaint (s) feel like? **Circle all** that apply: *Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other*________________



←Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.

Area for doctor's notes:

On the scale below, please circle the severity of your main complaint right now:

No Pain					*Moderate Pain*					*Worst Possible Pain*
0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

What area(s) does the pain radiate, shoot, or travel to? (if applicable)? ________________

What aggravates this complaint? **Circle all that apply:** Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward / Bending backward / Twisting / Reaching / Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other: ________________

What relieves this complaint? **Circle all that apply:** Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Laying down / Medication / Nothing / Unknown / Other: ________________

How often do you experience your symptoms? ☐ 25% of the day ☐ 50% of the day ☐ 75% of the day ☐ 100% of the day

Timing of complaint: **Check appropriate box:** ☐ Morning ☐ As day progresses ☐ Afternoon ☐ Evening ☐ While sleeping ☐ During activities ☐ After activities ☐ Symptoms are constant and do not change ☐ Other: ________________

With time are your symptoms: ☐ Improving ☐ Worsening ☐ Not changing

Have you seen other doctors for this complaint? ☐ Yes ☐ No If "Yes", please provide the following information:

Doctor's name: ________________Date consulted: ________________ Diagnosis ________________

Is this condition interfering with your: **(Circle all that apply)** Sleep / Getting in or out of bed or chair / Personal care / Travel / Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other: ________________

Is your complaint interfering with your daily activities? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

:

HEALTH HISTORY

Please check ALL of the health conditions below that apply to you currently or in the past				Family History Mark ALL conditions that run in your family (Father, Mother, Sister, Brother)		Relationship
☐	Osteoarthritis/Degenerative Joint Disease	☐	Whiplash Injury *Date of injury:*	☐	Cancer *Type:*	
☐	Asthma	☐	Headaches	☐	Anemia	
☐	Diabetes ☐ Type I ☐ Type II Was your blood/lab work test for hemoglobin A1c > 9.0%? ☐ Yes ☐ No ☐ Not Sure	☐	Joint Pain (circle location of pain): Shoulder, Elbow, Hip, Knee, Ankle Other: ___________	☐	Diabetes (check one) ☐Type I ☐ Type II	
☐	Anemia	☐	Migraines	☐	Heart Problems / Stroke	
☐	Cancer/Tumor	☐	Osteoporosis /Osteopenia	☐	High Blood Pressure	
☐	Rheumatoid Arthritis	☐	Epilepsy / Seizures	☐	Genetic Disorders	
☐	Depression/ Anxiety	☐	Fibromyalgia / Chronic Fatigue	☐	Rheumatoid Arthritis	
☐	Disc Herniation	☐	Genetic Disorders			
☐	High Blood Pressure /Hypertension	☐	Pregnant # of weeks: _________			
☐	Heart Disease / Stroke	☐	Please list any other medical conditions:			

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

____

Have you had an X-ray or CT scan or MRI? ☐ Yes ☐ No

SOCIAL HISTORY

Height ___ **ft** ___ **in.** **Weight** _____ **lbs**

Do you exercise? ☐ Yes ☐ No **Times per week?** **Intensity?** ☐ Light ☐ Moderate ☐ Strenuous Type?

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former smoker ☐ Never been a smoker # of packs/day ________ # of years __________

Do you drink alcohol? ☐ Yes ☐ No **How many drinks per week?** **For how many years?**

Do you drink caffeine? ☐ Yes ☐ No **How many drinks per day?** **What type?** ☐ Coffee ☐ Tea ☐ Soft Drinks ☐ Energy Drinks

Do you take pain killers? ☐ Yes ☐ No **How often?** ☐Daily ☐ Weekly ☐ Monthly ☐ Rarely **What type?** ☐ Aspirin ☐ Ibuprofen ☐ Tylenol ☐ Other

What do your work duties include? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Other:

Please describe your overall health right now? ☐ Excellent ☐ Very Good ☐ Good ☐Fair ☐ Poor

What is your current stress level? ☐ Mild ☐ Moderate ☐ High

Have you seen a chiropractor in the past? ☐ Yes ☐ No

List current prescription medications. If there are NO current medications check here. ○

Name of Prescription Medication	Dosage