Welcome to Crystal Chiropractic

Patient Information

Today's Date: ______________________ **Referred By:**___________________________________

Patient Name: ____

What do you prefer to be called? ____

Street Address: ____

City: ______________________________**State:** _________________**Zip:** ____________________

Sex: Male Female **SSN:** ________________________ **DOB:** ____________________

Marital Status: Minor Single Married Divorced Separated Widowed

Employer: ____

Email:(print)____

List the numbers in which Crystal Chiropractic can call and/or leave a message regarding appointments, Insurance coverage, or to return your call.

(Home)___________________ **(Cell)**_______________________ **(Work)**______________________

Insurance Information: *If you are the insured, skip the next two lines.*

Insured's Name: _______________________________________ **DOB:** _______________________
SSN: ___________________ **Relation**:_____________________**Employer:** ____________________

Who should we contact in the event of an emergency? ___________________________________
Relation: ___________________________________ **Phone #** _________________________________

Who is your Medical Doctor? ____

Please list any person who has permission to present your child for treatment:
N/A____

I acknowledge that I have received a copy of the Health Insurance Privacy Act, the consent for use or disclosure of health information, the appointment reminders and health care information, and a marketing authorization. This Notice is effective as of March 15,2011. This notice will expire six years after the date upon which the record was created.

Print Name: ________________________ **Sign Name:** ____________________________________
Date: ______________________________

Health History

Height: ____________ **Weight:** ____________________ **BMI:** _____________________ **Smoker:** Yes / No

What medications do you take, reasons, and date started? Example: nerve pills, pain killers, aspirin, muscle relaxers, stimulants, blood thinners, tranquilizers, cholesterol, insulin: ____

____

What supplements do you take? None ____

____

Family History: Cancer Diabetes High Blood Pressure Heart Problems Arthritis

Other____

Patient History: Do you have/had the following conditions: (circle all that apply)

Heart Attack/Stroke	Heart Surgery/Pacemaker	Heart Murmur	Mitral Valve Prolapse
Alcohol/Drug Abuse	Hepatitis/HIV+/Aids	Prostate Problems	Cancer/Chemotherapy
Arthritis	Severe/Frequent Headaches	Psychiatric Problems	Kidney problems
High/Low Blood Pressure	Ulcers/Colitis	Sinus problems	Fainting/Seizures/Epilepsy
Asthma/Breathing problems	Diabetes/Tuberculosis	Artificial Joints	Birth Control Pills

Other medical conditions:____

____

Allergies: food, medicine, seasonal, other:____

Serious Accidents/surgeries: ____

Are you interested in Nutritional Advice? Yes / No

Are you interested in Weight Loss? Yes / No

Do you Exercise? Yes / No

Do you have Orthotics or arch supports? Yes / No

Do you need new Orthotics? Yes / No

Is your mattress comfortable? Yes / No

Do you sleep on a cervical pillow? Yes / No

Are you pregnant? Yes / No weeks: ____________

Have you ever seen a Chiropractor before? Yes / No Whom? ________________________________

Was it for the same problem? ________________________ Did you get relief?____________________

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any change to the information that I have provided.

Signature:____Date:____/_____/_____

FOR DOCTORS USE ONLY--

Discussion: weight as a factor weight loss nutrition exercise smoking

Name____ **Date**____________________

LOCATION OF PAIN:______________________________How/when did it occur? ______________________________

____On scale of 1-10, rate your pain: _________(10 = severe)

What makes it feel better?____

Has this happened before? Y N As Bad? Y N What has helped it in the past? ______________________________
Have you seen a Doctor about this? Y N Who? _____________________ Did they do X-rays or MRI? Y N
____.

Describe the pain, use a (C) for constant and (I) for comes and goes: sharp__ stabbing__ aches__ spasms__ dull__ burning__ numbness__ tingling__. Does the pain shoot or radiate somewhere? Y N Where? ______________________________

Is the pain there: 0- ¼ -½ -¾ or 100% of the day? Does it affect your sleep? Y N How ______________________

Dr.Notes____
____

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Daily Activity Living Form

Name: ____________________________________ Date:___________________________

Your Insurance Company wants to know how your pain affects your daily life. Please be specific in what things you do every day that are affected. Circle and put a number beside how your pain affects your daily living. **Use a scale of 1-10 (10 = severe)**

Personal care:

____Bathing ____Showering ____Washing hair ____Drying hair

____Combing hair ____Brushing teeth ____making bed ____ putting on shirt

____putting on shoes ____ taking off shoes ____Tie shoes ____ putting on pants

____prepare a meal ____ eating ____clean dishes ____Doing laundry

____take out trash ____ going to toilet ____ getting out of bed ____ turning over in bed

Physical Activity:

____ standing ____ sitting ____ reclining ____bending ____twisting

____ kneeling ____ reaching ____ walking ____exercise ____ lifting

Functional Activity:

____ Caring a briefcase/purse ____ climbing steps _____ pushing a cart ____ sitting in a car

____ standing in a grocery ____ sitting at a computer ____reading ____ writing

____ focus/concentration

Below please list any other daily or job activities that are affected by your pain. List as many as you can. Put a number beside each one. **Use a scale of 1-10 (10 = severe)**

____

____

____

____

____

____

____

____

Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

Stabbing/Cutting - |||||
Burning – XXX
Numbness - =====
Tingling - : : : :
Cramping - ^^^
Dull - #####