first chiropractic CENTERS P.C.

Welcome to our office. Please complete this form to tell us how we can help you today.

firstchiropracticcenter.com

Patient Number _____
(office use only)

Today's Date: _____

_____ _____ _____
Your Last Name **Your First Name** **Middle Initial**

○ **I have new contact information** ○ **My smoking status has changed**

I am interested in: ○ Chiropractic Care ○ Stretches and Exercise ○ Nutritional Advice
○ Acupuncture ○ Wellness Care ○ Quit Smoking

1. Onset (When did you first notice your current symptoms?)

_____

2. Mechanism (How did this start?)

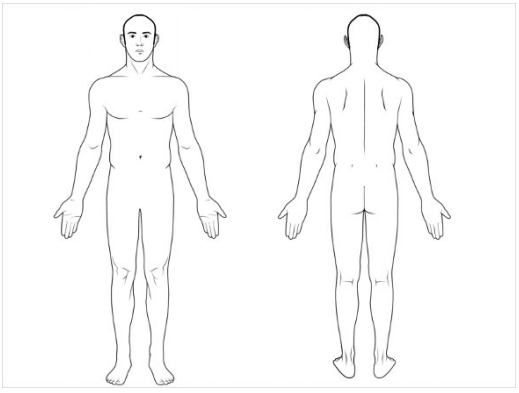
_____

3. Intensity (How extreme are your current symptoms?) Please mark below
0○-○-○-○-○-○-○-○-○-○-○**10**
Absent Uncomfortable Unbearable

4. Duration and Timing
○ Constant
○ Comes and Goes

5. Quality of Symptoms
(What does it feel like?)
○ Numbness
○ Tingling
○ Stiffness
○ Dull
○ Aching
○ Cramps
○ Nagging
○ Sharp
○ Burning
○ Shooting
○ Throbbing
○ Stabbing
○ Other_____

6. Location Where does it hurt?
(Circle the area(s)on the illustration)



7. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

_____

8. Prior Interventions (What have you done to relieve the symptoms?)
○Prescription Medication ○Surgery
○Over-the-Counter drugs ○Acupuncture
○ Physical Therapy ○Chiropractic
○Massage ○Heat ○Ice
○Other _____

9.Aggravating or Relieving Factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

10. What else should the doctor know about your current condition?

_____

Consultation Notes

Vitals: (completed by staff)
H: _____
W:_____
BP:_____
T:_____
P:_____
BMI:_____
Wizard Complete
_____

_____
Doctor's Initials

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_____
Patient Name

11. Review of Systems (Identify any changes since your most recent evaluation with us):

		Worse	No Change	Improved
a)	**Musculoskeletal System –** Such as osteoporosis, arthritis, joint pain	○	○	○
b)	**Neurological System –** Such as anxiety, depression, headache, dizziness, tingling, numbness	○	○	○
c)	**Cardiovascular System** – Such as high or low blood pressure, angina, chest pain	○	○	○
d)	**Respiratory System** – Such as asthma, apnea, emphysema, shortness of breath, pneumonia	○	○	○
e)	**Digestive System** – Such as ulcer, food sensitivity, heartburn, constipation, diarrhea	○	○	○
f)	**Sensory System** – Such as blurred vision, ringing in the ears, hearing loss	○	○	○
g)	**Skin System** – Such as skin cancer, psoriasis, eczema, acne, rash, mole changes	○	○	○
h)	**Endocrine System** – Such as thyroid issues, immune disorders, low blood sugar, diabetes	○	○	○
i)	**Genitourinary System** – Such as kidney stones, infertility, prostate issues, PMS Symptoms	○	○	○
j)	**Constitutional System** – Such as fainting, poor appetite, fatigue, frequent urination, weakness	○	○	○

12. Illnesses, operations, injuries or treatments since your most recent evaluation with us:

13. Please provide a list of your current medications, medication allergies and nutritional supplements
(We prefer to make a copy of your list with dosages included)

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):_____**

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **I may request a copy of the Financial Policy at any time.**

Initials ____ **I authorize my insurance company or administrator to pay First Chiropractic Centers, PC directly for the Benefits otherwise payable to me under my current policy**

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____ _____
Signature Date (MM/DD/YYYY)

If the patient is a minor child, print child's full name: _____

Doctor's Initials_____