ALPINE CHIROPRCTIC, PC

CONFIDENTIAL PATIENT INFORMATION

Today's Date _____

First Name _____ **Nick Name**_____

Last Name _____ **Middle Name** _____**Suffix** _____

Address 1 _____

Address 2 _____

Primary Phone _____ **Work Phone** _____

Mobile Phone _____ May we send appointment reminder test message ___ Yes ___ No

Email _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided

Date of Birth:_____ **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Name of Spouse _____ **Spouse Date of Birth** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Employer _____ Employer address _____

Current Medications including supplements:

1. _____ 4._____
2. _____ 5._____
3. _____ 6._____
7. _____ 8._____
9. _____ 10._____

Allergies to Medication:

1. _____ 3._____
2. _____ 4._____

Do you currently smoke tobacco? Yes____ **No**____ **Number of packs per day** ____ **Do you use smokeless tobacco? Yes** ___ **No** ____

Do you currently drink alcohol? Yes ___ **No** ____ **Number of drinks**____ **per day/week (circle one)**

Do you currently drink caffeinated soft drinks, coffee or tea? Yes ___ **No** ___ **(cups per day)** ____

Do you currently use recreational drugs? Yes____ **No** ___

Are you diagnosed with hypertension (High blood Pressure)? **Yes**____ **No**_____

Are you diagnosed with Diabetes? Yes_____ **No**_____ **If yes: Type 1**_____ **OR Type 2**_____

Verification Question (Choose One)

□ What is the name of your favorite pet? □ In what city were you born? □ What High School did you attend?

□ What is your favorite movie? □ What is your mother's maiden name? □ On what Street did you grow up on?

□ What is the make of your first car? □ When is your anniversary? **ANSWER:**_____

List present complaints, injuries, duration and when the symptoms or pain began:

_____

_____

Brief remarks and details of any recent related accident:

_____

_____

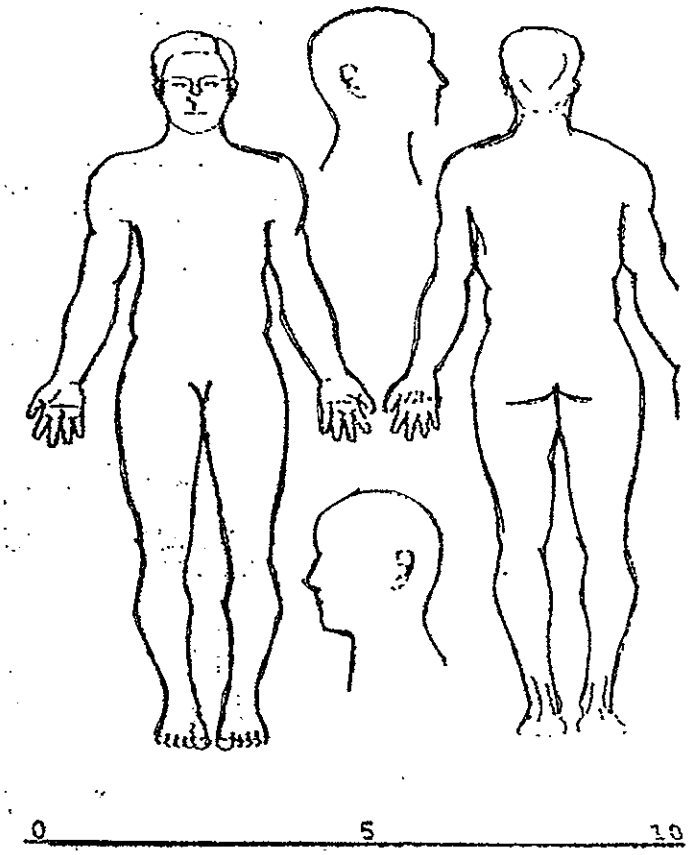
Are symptoms Getting worse _____ Getting better _____ The same ____

List any doctors consulted for present complaints and injuries:

Name: _____ **Phone:** _____

Address: _____

*** PLEASE MARK YOUR AREA
OF PAIN ON FIGURES ***



0 5 10

On a pain scale of 0 to 10, 0(zero) being no pain at all and 10 being extreme pain, please mark the level of your pain.

PLEASE CIRCLE CURRENT CONDITIONS

GENERAL SYMPTOMS E.E.N.T.

HEADACHE
FAINTING
DIZZINESS
CONVULSIONS
LOSS OF SLEEP
FATIGUE
NERVOUSNESS
WEIGHT GAIN/LOSS
ALLERGY
DEPRESSION

CARDIOVASCULAR

HIGH BLOOD PRESSURE
LOW BLOOD PRESSURE

FOR WOMEN ONLY

PAINFUL MENSTRUATION
HOT FLASHED
IRREGULAR CYCLE
CRAMPS OR BACKACHE
MENOPAUSAL SYMPTOMS
PREGNANCY

TINNITUS
ASTHEMA
FREQUENT COLDS
ENLARGED THYROID
TONSILLITIS
SINUS INFECTION
NASAL DRAINAGE

MUSCLE & JONT

STIFF NECK
NECK ACHE
BACKACHE
SWOLLEN JOINTS
PAIN IN SHOULDERS
PAINFUL TAILBONE
SPINAL CURVATURE
FAULTY POSTURE
ARTHRITIS

CARDIOVASCULAR

PAIN OVER HEART
PREVIOUS HEART ATTACK
HARDEING OF ARTERIES
SWELLING OF ANKLES
POOR CIRCULATION
PARALYTIC STROKE
ANEURYSM

GASTRIONESTINAL

DIFFICULT DIGESTION
BELCHING/GAS
NAUSEA
VOMITING
VOMITING OF BLOOD
PAIN OVER STOMACH
CONSTIPATION
COLON TROUBLE
GALL BLADDER TROUBLE
HERNIA

HAVE YOU HAD ANY OF THE FOLLOWING

APPENDICITIS
CANCER
HEART DISEASE
STROKE
HIGH CHOLESTROL
DEPRESSION
ANXIETY
MENTAL DISORDER
LOW BACK SURGERY
NECK SURGERY

DIABETIES
PHYCHOLOGICAL DISORDER
ECZEMA
DRUG DEPENDENCY
PLEURISY
FIBROMYALGIA
GASTRO INTESTIONAL DISORDER
H.I.V.
AIDS
OTHER _____

EPILEPSY
ANEMIA
GOITER
EMPHYSEMA
ASTHMA
OSTEOPOROSIS
ALCOHOLISM
LIVER DISEASE

JOINT REPLACEMENTS? PLEASE LIST _____

DO YOU HAVE A PERMANENT DISABILITY RATING? _____ LOCATION _____ DATE _____

PAST HEALTH HISTORY

What surgeries have you had and/or fractures or broken bones, etc?

Type/when/ DR _____

_____

List former serious accident, injuries and/or falls: (auto, work, home, leisure, etc) _____

What/when/symptoms/treatment _____

Do you wear orthotics, heel or sole lifts in your shoes? _____

OCCUPATIONAL

SEATED/STANDING WORK BENCH/DESK COUNTER/OTHER

Job involves -- Lifting/bending/stooping/twisting/turning/carrying/walking/standing/other please circle

Shoes -- High heels/boots/athletic/other

Do any work activities aggravate present main complaints? _____ Describe _____

LEISURE

Sendentary activities Describe _____

Strenuous activities -- sports/exercise -- Describe _____

How would you grade your general stress level:

No stress _____ Minimal stress_____ Moderate stress _____ Greatly stressed _____

Physical activity at work

Sendentary more than 50% of workday _____ Light manual labor _____ Manual _____ Heavy _____

General physical activity

No regular program _____ Light exercise _____ Strenuous exercise _____

X-RAY CONFIRMATION:

THIS IS TO CONFIRM THAT I HAVE BEEN ADVISED BY THIS OFFICE THAT X-RAYS CAN BE HAZARDOUD TO AN UNBORN CHILD.

AT THIS TIME, TO THE BEST OF MY KNOWLEDGE, I AM NOT PREGNANT, AND I CONSENT TO SPINOGRAPHIC X-RAYS.

SIGNED _____

CONSENT TO TREAT A MINOR CHILD:

I HEREBY AUTHORIZE THIS OFFICE TO ADMINISTER CHIROPRATIC CARE AS DEEMED NECESSARY TO MY CHILD

PARENT/LEGAL GUARDIAN SIGNATURE _____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THIS CHIROPRACTIC OFFICE MAY PREPARE ANY NECESSARY REPORTS AND FORM TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAY ANY AMOUNT AUTHIROZED TO BE PAID DIRECTLY TO THIS CHIROPRACTIC OFFICE WILL BE CREDITED TO MY ACCOUNT ON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME, AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

PATIENT'S SIGNATURE _____ DATE _____

GUARDIAN OR SPOUSE _____ DATE _____

INFORMATION TAKEN BY _____ DATE _____

To be performed by clinic staff:

Height:_____inches **Weight:**_____pounds **BP:**_____/_____