# PATIENT INFORMATION

IN ORDER FOR US TO BEST SERVE YOU, PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION:

Date: ___________________________

Patient Name: ______________________________________________ Date of Birth:____________________

Home Address: ________________________________ City:__________________ State:___ Zip: ________

Cell Phone: __________________ Home Phone:_________________ Work Phone:____________________

Email: _______________________________________ How did you hear about us?_____________________

Employer: _______________________________ Address:__________________________________________

Name of Spouse/Guardian: _________________________________ Date of Birth:______________________

Spouse's/Guardian's Employer: ____________________ Address: __________________________________

Emergency Contact: ___________________________Phone No.: __________________Relationship:______

Who is responsible for payment? ❑ Self ❑ Spouse ❑ Guardian ❑ Other: _______________________

**PRIMARY INSURANCE:**

Name of Insurance: ____________________________

ID No.:_______________________________________

Group No.: ___________________________________

**SECONDARY INSURANCE:**

Name of Insurance: ________________________

ID No.: _____________________________________

Group No.: __________________________________

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**Purpose of this appointment/describe your complaint(s):** ______________________________________

_____________________________________________________________________________________

Date of Injury/Illness: _________________Time: _______ ❑ AM ❑ PM Location:___________________

How did the injury occur? ❑ Auto ❑ On the job ❑ Other: ______________________________________

**Please describe the circumstances and what makes the condition(s):**

Better: _______________________________________________________________________________

Worse: _______________________________________________________________________________

Other Doctor seen for this condition: ____________________________________________________________

Have you been treated by a doctor for any other health condition since your last visit? ❑ No ❑ Yes

If yes, please describe: __________________________________________________________________

Have you had any new falls/accidents/surgeries since your last visit? ❑ No ❑ Yes ______________________

List any medications you are currently taking: _______________________________________________

PAYMENT POLICY

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Durham Family Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Durham Family Chiropractic will be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am responsible for payment. I also understand that if I suspend or terminate my treatment, any fees for professional services rendered to me will be immediately due and payable. If I cannot keep your appointment and I do not call or email the office prior to my appointment time I understand that I will be charged a fee of $25.00

Signature of Physician: _________________________Signature of Patient:____________________________

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic services he/she deems necessary in my case; and I further authorize the him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, worker's compensation carriers, welfare funds or the patient's employer.

Signature of Patient: _________________________ Parent's/Guardian's Signature:_____________________

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

## MUSCULOSKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Spasms
- ❑ Broken bones
- ❑ Shoulder problems

## GENITO-URINARY SYSTEM

- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

## FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast

**ARE YOU PREGNANT?**

❑ **YES** ❑ **NO**

## GASTRO-INTESTINAL SYSTEM

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficulty chewing
- ❑ Difficulty swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

## NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of Feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscle Jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia

## HABITS

- ❑ Smoking
- ❑ Alcohol use
- ❑ Coffee or tea:
- ❑ Drug abuse

## CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficulty breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose veins

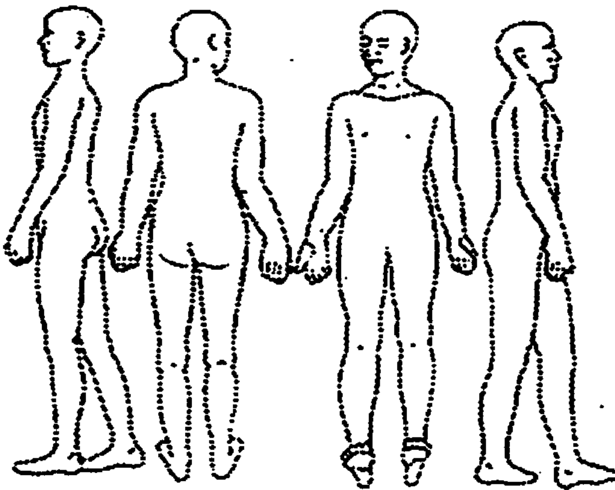
## EYE, EAR, NOSE & THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficulty breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficulty with speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw pain

## PLEASE MARK ON THE BODY WHERE YOU EXPERIENCE THE FOLLOWING SYMPTOMS:

P ___ Pain
N ___ Numb
S ___ Spasm

T ___ Tender
H ___ Hypoesthesia
(decrease of sensitivity)



Patient Signature: ____________________

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Pain-free | Very Mild | Discomforting | Tolerable | Distressing | Very Distressing | Intense | Very Intense | Utterly Horrible | Excruciating/ Unbearable | Unimaginable/ Unspeakable |

| NO PAIN | MINOR PAIN | MODERATE PAIN | SEVERE PAIN |
|---|---|---|---|
| You're living life as usual. | Pain doesn't limit your activity; you're still living a normal life with a little bit of pain added in. | Your pain is somewhat disabling – you might avoid activities that exacerbate it. | Your pain is extremely disabling. It has drastically affected your quality of life and is always on your mind. |