Fifth Avenue
CHIROPRACTIC
Your Road to Better Health

Confidential Patient Information

(Please Print)

Patient Information **Acct#**_____

Dr./Mr./Mrs./Ms./Miss *(circle one)* Marital Status *(circle one)* M S W D

_____

Last Name First Name Middle Initial Nick Name

_____

Address City State Zip Code

Sex [ ]M [ ]F Height_____ Weight_____

Mobile phone#_____Home phone# _____

Email address _____

Social Security No_____Date of Birth_____

Occupation_____Employer_____

Work Address_____Work Phone# _____

Work duties_____

Person to contact in an emergency_____ Phone# _____

Preferred Method of Contact: __Home Phone __Mobile Phone __Other

Race __American Indian or Alaska Native __Asian __Black or African American
__Hispanic or Latino __White __Not Provided

Ethnicity __Not Hispanic or Latino __Hispanic or Latino

Preferred Language __English __Spanish

Primary Care Physician
We would like to keep your doctor informed regarding your care. Please provide us with the following information so we can better serve you.

Doctor's Name Practice Name Phone Number

Symptoms

1. What is your **number one** problem or the **one area** of greatest pain? _____

_____

2. Please rate the level of this pain on the following scale: **0 is no pain, 10 is severe pain** or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain. **0 1 2 3 4 5 6 7 8 9 10**

3. When did this problem/pain start_____[ ] Gradual [ ] Sudden [ ] Progressive

4. What do you think caused this problem? _____

5. How often do you experience the pain?

__1-2 hours per day __About half of the day

__Most of the day __The pain never goes away

6. How does the pain effect your daily activities?

___It does not effect my daily activities

___I have had to change how I do things

___I have had to stop doing some of my daily activities

___I am unable to perform daily activities

7. What **increases** your pain?_____

8. What **decreases** your pain? _____

9. Have you ever experienced this problem before? [ ] Y [ ] N When?_____

10. Have you been treated by another physician for this condition? [ ]Y [ ] N

If so, whom and when?_____

11. List any other complaints currently bothering you and rate your pain level for each.

a. _____ **0 1 2 3 4 5 6 7 8 9 10**

b. _____ **0 1 2 3 4 5 6 7 8 9 10**

c. _____ **0 1 2 3 4 5 6 7 8 9 10**

d. _____ **0 1 2 3 4 5 6 7 8 9 10**

12. Have you ever been involved in an automobile accident? [ ] Y [ ] N When? _____

Were you injured? [ ] Y [ ] N Explain _____

13. Have you ever been injured at work? [ ] Y [ ] N When?_____

Explain _____

14. List all medication you are currently taking (prescribed and over the counter)_____

_____

15. List all drug allergies you have _____

16. List all surgeries you have had (with date) _____

_____

If you have experienced any of the following conditions in the past mark with a "**P**" on the line provided.
If you are currently experiencing any of the following conditions please mark a "**C**" on the line provided.
(check all that apply)

__hip pain	__shoulder pain	__arm/hand pain	__mid back pain
__low back pain	__disc pain	__leg pain	__knee pain
__foot pain	__headaches	__migraines	__arthritis
__joint swelling	__other joint pain	__numbness	__dizziness
__nausea	__ringing in ears	__muscle weakness	__gout
__ulcers	__vision changes	__hearing changes	__earaches
__nose bleeds	__asthma	__persistent cough	__chest pains
__frequent colds	__digestive problems	__urinary problems	__female problems
__prostate problems	__high blood pressure	__diabetes	__constipation
__diarrhea	__insomnia	__fatigue	__seizures
__cancer	__osteopenia	__osteoporosis	__sprained ankle [ ] R [ ] L
__difficulty with bowel movements		__broken bones(specify)_____	

Is there any other medical history you would like us to know? _____

General Activities (check all that apply)

__sleep on waterbed	__read in bed	__fall asleep in recliner/on couch
__sleep on stomach	__needlepoint/knitting	__use two or more pillows to sleep
__sewing	__lift weights.wt. mach.	__play video games (___hrs per day)
__jog_____x/wK	__swim	__computer use (___hrs per day)
__exercise_____x/wk	__use treadmill	__watch television (___hrs per day)

Please add anything else you would like the doctor to know: _____

_____

_____

_____

Nutrition __avg. servings of fruits and vegetables/day __glasses of H2O/day
Do you take vitamins or minerals? Y/N
Habits: Circle (H) Heavy, (M) Moderate, (L) Light, or (N) None Alcohol: H/M/L/N
Caffeine: H/M/L/N Tobacco: H/M/L/N Have you ever smoked in the past? Y/N
Do you wear: heel/sole lifts:
Y/N Arch Supports: Y/N Orthotics: Y/N

Family Health History: Many health problems can be related to hereditary illnesses or spinal weakness; thus information about your family members will give us a better idea of your total health picture. Check all that apply.

Father:__heart disease __diabetes __cancer (type_____) __arthritis __deceased N/Y Cause of death_____
Mother: __heart disease __diabetes __cancer (type_____) __arthritis __deceased N/Y Cause of death_____
Siblings: __heart disease __diabetes __cancer (type_____) __arthritis __deceased N/Y Cause of death_____
__heart disease __diabetes __cancer (type_____) __arthritis __deceased N/Y Cause of death_____
__heart disease __diabetes __cancer (type_____) __arthritis __deceased N/Y Cause of death_____

Responsible Party

Name of person responsible for payment of this account_____
Relationship to patient_____ Phone # _____
_____
Address City State Zip Code

Insurance

Most insurance companies cover Chiropractic care, but this office makes no representation that yours does. As a courtesy, we will do our best to verify your insurance coverage and will bill your insurance in a timely manner. Be aware that any information your insurance company give to us regarding coverage may not be an accurate representation of how they actually will pay, that determination is made at the time they process the claim. Due to variance from one insurance policy to another we require you, the patient, to be personally responsible for the payment of your deductibles, co-insurance, and co-payment amounts.

Primary Insurance
Name of Insurance Company _____
Name of Insured _____
Birthdate of Insured _____
Insured's ID # _____
Insured Group # _____

Secondary Insurance
Name of Insurance Company _____
Name of Insured _____
Birthdate of Insured _____
Insured's ID # _____
Insured Group # _____

In order for us to properly bill and get reimbursed by your insurance company please read and sign the following Authorization and Assignment statement.

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this Fifth Avenue Chiropractic

Patient's Signature_____Date _____
(Signature of parent if the patient is a minor)

Doctor's Comments:_____

_____

_____

_____

_____

_____

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_____

Doctor's Signature_____ Date _____