Confidential Patient Information

Welcome to Dominion Family Chiropractic Center. If you have any questions while filling this form out, please do not hesitate to ask. We are always happy to answer any questions you may have.

Name____ **Sex** M F **Date** ___________

Address________________________ **City** __________________ **State**______ **Zip**_________

Phone #s: Home: _______________ **Work:**________________ **Cell:**__________________

E-mail address_______________@_________________

Would you like to receive our monthly newsletter via email? Y N

Date of Birth:_____/_____/______ **Age:** _____**Marital Status: Married Single Widowed**

Social Security #_______-_______-________ **Employer/Occupation** ___________________

Emergency Contact Name: _____________________ **Phone #**_________________________

How did you hear about us? ____

Referred By: ________________ **Current Primary Care Physician**____________________

Health Insurance Information: Do you have health insurance? Yes No **Please give your insurance card to the receptionist.**

Company:___________________ **Policy / Group #** _________________________________

Are you the primary policy holder? Y N If not, please fill in the following information:

Primary policy holder's name: __________________ **Date of Birth:**_____/_____/_______

Relationship to you: (circle) Spouse Parent Other

Have you ever received Chiropractic Care? Yes No If yes, when? _______________

Were your results satisfactory? Y N

Note: **If you have RECENTLY been involved in an automobile injury, please request and fill out our accident report form which may be obtained from the front desk.**

Health History

1. **Are you under the care of another doctor?** Yes No
2. **If so, for what condition / conditions?**
   ____

3. **Past Health History:**

Check the following conditions you may have had or do have now:

_____Allergy	_____Gout	_____Nervousness	_____Whooping Cough
_____Alcoholism	_____Gall Bladder	_____Depression	_____Low Blood Sugar
_____Anemia	_____High Bld Pressure	_____Pleurisy	_____Neck Pain
_____Arteriosclerosis	_____Heart Disease	_____Pneumonia	_____Back Pain
_____Arthritis	_____Malaria	_____Polio	_____Chest Pains
_____Backaches	_____Menstrual Cramps	_____Headaches	_____Indigestion
_____Cancer	_____Irregular Cycles	_____Ears Ringing	_____Numbness
_____Convulsions	_____Migraine	_____Rheumatic Fever	_____Allergy
_____Constipations	_____Epilepsy	_____Stroke	_____Other
_____Diabetes	_____Measles	_____Heart Attack	_____Gout
_____Sinus	_____Miscarriage	_____Tuberculosis	_____Nervousness
_____Diarrhea	_____Multiple Sclerosis	_____Ulcers	_____Emphysema
_____Eczema	_____Mumps	_____Thyroid Problems	_____Neuritis

4. **Previous injuries or trauma:**____

5. **Have you ever broken any bones?** ______ **Which?** ______________________________

6. **Allergies** ____

7. **Medication** **Reason for taking**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

8. **Surgeries: Date** **Type of Surgery**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

9. **Females - Pregnancies:**

Pregnancies / Date of Delivery C-Section / Other Complications

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

What was the date of the beginning of your last menstrual period? ____________________

Patient Name: ______________________ Date: ______________________

Health History Continued

10. Family Health History:

Major health problems of close relatives: ____

Deaths in immediate family – Cause of parents or siblings death:

Relationship:	Age at death	Relationship:	Age at death
____________________________	___________	_____________________	__________
____________________________	___________	_____________________	__________

11. Occupational History:

A. Job description:
____

B. Work schedule:
____

C. Recreational activities:
____

13. Lifestyle:

A. Do you use tobacco? Y N

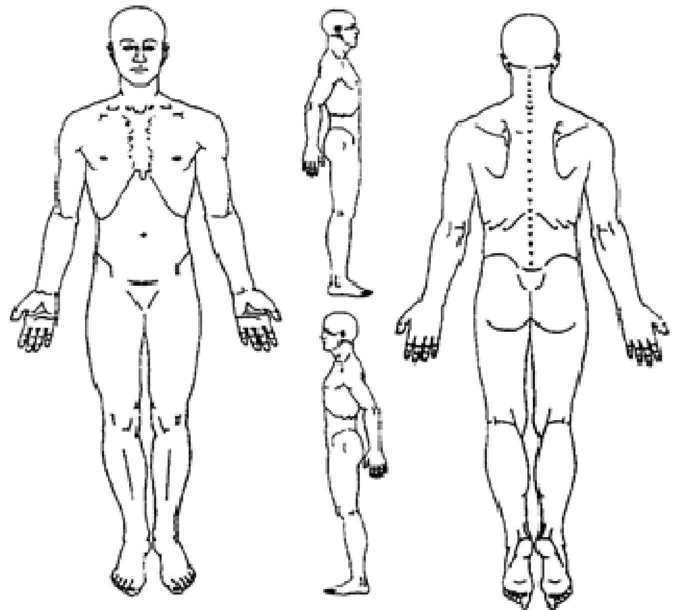
B. How often do you exercise? ______________

C. Are you on a special diet? ________________

12. Is there anything else you think we should know about your health history?

____
____
____
____

The Reason for Your Visit Today



1. Why are you being seen today?

____

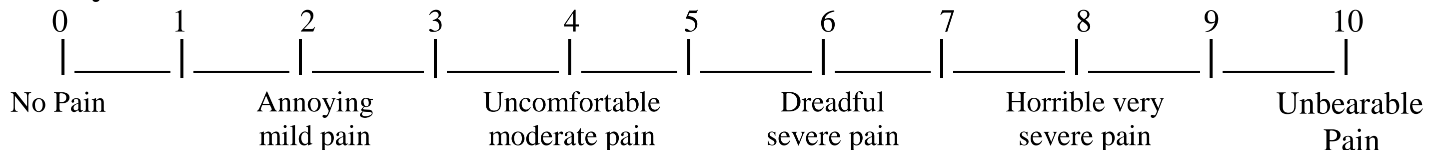
____

2. Using the diagram on the right, please circle the area / areas that you feel pain.

3. For each area of pain, please answer the following questions:

Area 1 Location: ______________________________

1. Using the pain scale below, please <u>circle</u> the <u>number</u> that best describes the pain as you usually feel it.



2. What do you think may have caused this pain to start? _________________________________

____

3. Can you pinpoint a date that this pain began? Y N Date:_____________________________

4. If a date cannot be given for #3, how did the pain begin? Circle one of the following:

Started gradually & became worse over time <u>OR</u> Has come and gone for a long time

Other:____

5. Since this pain began, how would you describe its frequency?

I feel pain in this area for about: 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% (circle one) of the DAY WEEK or MONTH (circle one)

6. When the pain begins, how long does it usually last? __________________________________

7. Describe the type of pain or you are currently experiencing. (check all that apply)

□ Aching □ Burning □ Cramps □ Dull □ Numbness □ Sharp □ Shooting □ Stabbing □ Stiffness □ Swelling □ Throbbing □ Tingling □ Other, describe it: _____________

The Reason for Your Visit Today continued

8. Is there any time of the day when the pain is worse or better? Y N if so, please circle one of the below:
My pain is worse / better in the morning. My pain is worse / better in the evening
Other: ____

9. Does the pain in this area seem to radiate to other areas? Y N

If the pain radiates, where does it radiate to? Up Down Left Right All Around
(circle one)

10. What activities make the pain worse?
□ Sitting □ Sleeping □ Standing □ Looking up □ Looking down □ Typing □ Sneezing □ Walking □ Coughing □ All movement □ House chores □ Bending □ Straining □ Exercise □ Rest □ Stooping □ Reaching □ Laying on my back □ Laying on my stomach □ Lifting □ Twisting □Driving □ Stair Stepping □ Other, describe it: _______

11. What makes the pain better? ____

12. What daily activities does this pain affect? _____________________________________

13. What are some things you can no longer do since the pain began? _________________

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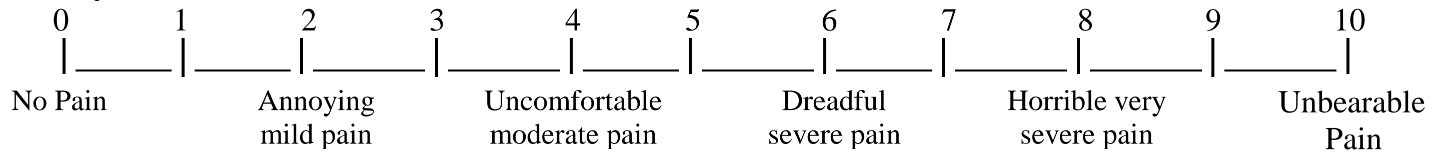
14. Previous interventions, treatments, medications, surgery, or care you've sought for this pain: ____

____

Area 2 Location: __________________________ (if you have a third area of pain, please let our Chiropractic Assistant know and she will give you another form)

1. Using the pain scale below, please <u>circle</u> the <u>number</u> that best describes the pain as you usually feel it.



2. What do you think may have caused this pain to start? ______________________________

____

3. Can you pinpoint a date that this pain began? Y N Date:________________________

4. If a date cannot be given for #3, how did the pain begin? Circle one of the following:

Started gradually & became worse over time <u>OR</u> Has come and gone for a long time

Other:____

5. Since this pain began, how would you describe its frequency?

I feel pain in this area for about: 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% (circle one) of the DAY WEEK or MONTH (circle one)

6. When the pain begins, how long does it usually last? _____________________________

7. Describe the type of pain or you are currently experiencing. (check all that apply)

□ Aching □ Burning □ Cramps □ Dull □ Numbness □ Sharp □ Shooting □ Stabbing □ Stiffness □ Swelling □ Throbbing □ Tingling □ Other, describe it: ____________

8. Is there any time of the day when the pain is worse or better? Y N if so, please circle one of the below:
My pain is worse / better in the morning. My pain is worse / better in the evening
Other: ____

9. Does the pain in this area seem to radiate to other areas? Y N

If the pain radiates, where does it radiate to? <u>Up</u> <u>Down</u> <u>Left</u> <u>Right</u> <u>All Around</u> (circle one)

10. What activities make the pain worse?
□ Sitting □ Sleeping □ Standing □ Looking up □ Looking down □ Typing □ Sneezing □ Walking □ Coughing □ All movement □ House chores □ Bending □ Straining □ Exercise □ Rest □ Stooping □ Reaching □ Laying on my back □ Laying on my stomach □ Lifting □ Twisting □Driving □ Stair Stepping □ Other, describe it: _______

11. What makes the pain better? ____

12. What daily activities does this pain affect? _____________________________________

13. What are some things you can no longer do since the pain began? _________________

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14. Previous interventions, treatments, medications, surgery, or care you've sought for this pain: ____

____

Name of person responsible for payment:____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. I understand and agree that health insurance policies are an arrangement between my insurance carrier and myself. I authorize Dominion Family Chiropractic Center to prepare and release any necessary reports and forms to assist in making collection from my insurance company and any amount authorized to be paid to Dominion Family Chiropractic Center will be credited to my account on receipt. I understand that I am personally responsible for payment of all balanced incurred for services rendered me at Dominion Family Chiropractic Center. 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 Signature: _________________________________ Date _________

Dominion Family Chiropractic Center
Dr. Barry H. Stewart D.C.

630-B Cedar Road   Route 460
Chesapeake   Suffolk/Windsor
(757) 547-4000

Authorization to Release Records

I ____ do hereby give permission and authorization to Dr. Barry H. Stewart, D.C., 630 – Cedar Road, Chesapeake, VA 23322, to receive copies of my patient records to include Diagnostic test results, MRI reports, and X-Ray reports from the following:

____

____

____

____

I further give my permission to the staff of Dominion Family Chiropractic to discuss my examination and treatment with the above named office and doctor should that need occur.

Signed: ____

Date: ____