# Physicians Plus Spine and Rehab Center
# Patient Health History Form

In order to provide you the best possible wellness care, please complete all pages of this form during your first appointment. All pages are required. All information is strictly CONFIDENTIAL.

## HOW DID YOU HEAR ABOUT US?

Referring new patients to our office is the highest compliment we can receive. Please take a moment to let us know ALL the ways you heard about our office. Put a check next to each source and then CIRCLE the main reason you selected this office.

Thank you!

**Patient Name: _____**

**__ Physician referral (Please list name below)**

**__ Internet**

**__ Family Member/Sibling**

**__ Office Incentive (contest/free consultation flyer)**

**__ Insurance company**

**__ Direct mailings**

**__ Newspaper**

**__ Other:_____**

**Please list the names of whom referred you to us (if applicable so we may thank them properly):**

_____

_____

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**Patient Data**

Name _____ Date _____ Email _____

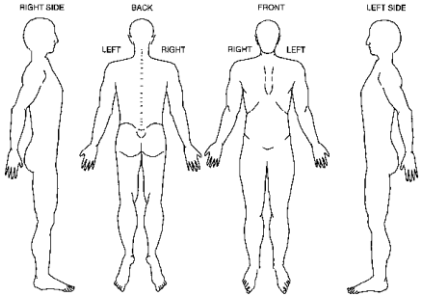
**Patient Information**

Address _____ City _____ State _____ Zip _____
Telephone (best number to reach you by) _____
Family Dr._____
Age _____ Birth date _____ Social Security # _____
Occupation _____ Employer_____
Marital Status _____ Spouse's name _____
Emergency contact _____ Phone _____

**Insurance Information**

Do you have health insurance? ❑ No ❑ Yes
Primary Insurance company _____
Phone _____ ID#_____ Group #_____
Secondary Insurance company (if any)_____
Phone_____ ID#_____ Group #_____

**CURRENT COMPLAINTS:** INDICATE ALL AREAS OF COMPLAINT ON THE DIAGRAM PROVIDED:



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PLEASE DESCRIBE SYMPTOMS BELOW: (START AT THE TOP OF YOUR BODY AND WORK YOUR WAY DOWN, I.E HEADACHE, NECK PAIN, ETC.)

**SYMPTOM 1_____**

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  0 1 2 3 4 5 6 7 8 9 10
- What caused your symptoms and when did they begin?
  _____
- What makes the symptoms worse?
  Bending neck forward, Bending neck backward, tilting head to the left, tilting head to the right, turning head to the left, turning head to the right, bending forward at the waist, bending backward at the waist, tilting left at the waist, tilting right at the waist, twisting left at the waist, twisting right at the waist, sitting, standing, getting up from sitting, lifting, driving, walking, running, sleeping, any movement, other (please describe)_____
- What makes the symptoms better?
  Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing,
  Other_____
- Describe the quality of symptoms (circle all that apply)
  Sharp, Dull, Achy, Burning, Throbbing, Piercing, Stabbing, Deep, Nagging, Shooting, Stinging,
  Other_____
- Does the symptom radiate to another part of your body (circle one): YES NO
- If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day

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**SYMPTOM 2_____**

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  0 1 2 3 4 5 6 7 8 9 10
- What caused your symptoms and when did they begin?
  _____
- What makes the symptoms worse?
  Bending neck forward, Bending neck backward, tilting head to the left, tilting head to the right, turning head to the left, turning head to the right, bending forward at the waist, bending backward at the waist, tilting left at the waist, tilting right at the waist, twisting left at the waist, twisting right at the waist, sitting, standing, getting up from sitting, lifting, driving, walking, running, sleeping, any movement, other (please describe)_____
- What makes the symptoms better?
  Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing,
  Other_____
- Describe the quality of symptoms (circle all that apply)
  Sharp, Dull, Achy, Burning, Throbbing, Piercing, Stabbing, Deep, Nagging, Shooting, Stinging,
  Other_____
- Does the symptom radiate to another part of your body (circle one): YES NO
- If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day

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**SYMPTOM 3_____**

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  0 1 2 3 4 5 6 7 8 9 10
- What caused your symptoms and when did they begin?
  _____
- What makes the symptoms worse?
  Bending neck forward, Bending neck backward, tilting head to the left, tilting head to the right, turning head to the left, turning head to the right, bending forward at the waist, bending backward at the waist, tilting left at the waist, tilting right at the waist, twisting left at the waist, twisting right at the waist, sitting, standing, getting up from sitting, lifting, driving, walking, running, sleeping, any movement, other (please describe)_____
- What makes the symptoms better?
  Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing,
  Other_____
- Describe the quality of symptoms (circle all that apply)
  Sharp, Dull, Achy, Burning, Throbbing, Piercing, Stabbing, Deep, Nagging, Shooting, Stinging,

  Other_____

- Does the symptom radiate to another part of your body (circle one): YES NO
- If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day

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**Name of Current PCP:** **Date of Last Physical Exam:**

**CURRENT MEDICATIONS:**

_____

_____

_____

_____

**ALLERGIES:**

_____

_____

_____

**Surgeries:**

**Date** **Type of Surgery**

_____

_____

_____

**Social and Occupational History:**

a. **Job description** _____
b. **Work schedule** _____
c. **Recreational activities/Hobbies**_____
d. **Lifestyle: Exercise ___days/week Alcohol ___/week Tobacco: ___ packs/day/week**

**REVIEW OF SYSTEMS (Please circle all that apply)**

**Pulmonary (lung-related)**

- **Asthma/difficulty breathing**
- **COPD**
- **Emphysema**

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- **Other_____**
- **none**

**Cardiovascular (heart-related)**

- **Heart surgeries**
- **Congestive Heart Failure**
- **Murmurs or valvular disease**
- **Heart attacks/Mis**
- **Heart Disease/problems**
- **Hypertension (high blood pressure)**
- **Pacemaker**
- **Angina/chest pain**
- **Irregular heartbeat**
- **Other _____**
- **none**

**Neurological (nerve-related)**

- **Visual changes/loss of vision**
- **One-sided weakness of face or body**
- **History of seizures**
- **Stroke/TIAS**
- **Headaches**
- **Memory loss**
- **Tremors**
- **Vertigo**
- **Other_____**
- **none**

**Endocrine (glandular/hormonal)**

- **Thyroid disease**
- **Hormone replacement therapy**
- **Injectable steroid replacements**
- **Diabetes- TYPE_____**
- **Other_____**
- **none**

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**Renal (kidney-related)**

- **Renal Calculi/Stones**
- **Hematuria (blood in the urine)**
- **Incontinence (can't control)**
- **Bladder infections**
- **Difficulty urinating**
- **Kidney Disease**
- **Dialysis**
- **Other _____**
- **none**

**Gastroenterological (stomach-related)**

- **Nausea**
- **Difficulty swallowing**
- **Ulcerative disease**
- **Frequent abdominal pain**
- **Hiatal hernia**
- **Constipation**
- **Pancreatic disease**
- **Irritable bowel/colitis**
- **Hepatitis or liver disease**
- **Bloody or black tarry stools**
- **Vomiting Blood**
- **Bowel incontinence**
- **Gastroesophageal reflux/heartburn**
- **Other _____**
- **None**

**Dermatological (skin-related)**

- **Significant burns**
- **Significant rashes**
- **Skin grafts**
- **Psoriatic Disorder**
- **Other_____**
- **none**

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**Musculoskeletal (bone/muscle-related)**

- **Rheumatoid arthritis**
- **Gout**
- **Osteoarthritis**
- **Spinal fractures**
- **Spinal surgeries**
- **Arthritis (unknown type)**
- **Metal Implants**
- **Other _____**
- **none**

**Psychological**

- **Psychiatric diagnosis**
- **Depression**
- **Suicidal ideations**
- **Bipolar disorder**
- **Homicidal ideations**
- **Schizophrenia**
- **Psychiatric hospitalizations**
- **Other _____**
- **none**

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## Patient request for Patient Records

**Date**: _____/_____/_____

**Attention:** _____

**Patient Name**: _____

**I hereby authorize the release of my X-Rays/Medical Records and request that they be transferred to:**

***Physicians Plus Spine and Rehab Center***

***1106 Pulaski Hwy.***

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**Informed Consent for Chiropractic Care**

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care many be contraindicated. Again, it is the responsibility of the patient to make known or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at a Health Care Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature:_____

Date:_____

Witness:_____

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# Physicians Plus Spine and Rehab Center

## PREGNANCY WAIVER

I hereby acknowledge that Physicians Plus Spine and Rehab Center has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

_____

Printed Name of Patient

_____

Signature of Patient/Authorized Representative of Patient

_____

Witness:_____

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**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 certify that I, and/or my dependent(s), assign directly Physicians Plus Spine and Rehab Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.**

**The above-named facility may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.**

**PATIENT or GUARDIAN/PERSONAL REPRESENTATIVE**

**SIGNATURE**_____

**DATE** _____