# AVON CHIROPRACTIC

## Patient Information

Name:_____ Birth date:_____ Age:_____ Sex: M F

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Mobile:_____ Email:_____

□Single □Separated □Married □Divorced □Widowed Social Security Number:_____

Employer:_____ Occupation:_____ Work Phone:_____

Family Doctor:_____ How did you hear about us?_____

Have you ever been to a chiropractor before? □Yes □No If yes, who did you see?_____

What kind of results did you have?_____

**In case of emergency, contact (name):** _____

Relationship:_____ Home Phone:_____ Mobile:_____

## Current Condition

What is the reason for your visit today? _____

Is your condition due to an accident? □Yes □No Type of accident: □Auto □Work □Home □Other

Have you made a report of the accident? □Auto Insurance □Employer □Worker Comp □Other _____

Attorney Name (if applicable):_____

How will you be paying for your care? □Cash □Check □Credit Card □Insurance:_____

## Health History

**Height:** _____ **Weight:** _____

Females: Are you currently pregnant? Y N

In the past three months have you had or do you experience (Circle **Y**es or **N**o):

Nausea/Vomiting……Y N
Fevers/chills/sweats……Y N
Unexplained weight loss……Y N
Numbness or tingling……Y N
Change in appetite……Y N
Difficulty swallowing……Y N
Shortness of breath……Y N
Dizziness……Y N
Urinary tract infection……Y N
Bowel or bladder changes……Y N
Upper respiratory infection……Y N

Do you have a history of (Circle **Y**es or **N**o):

Allergies/asthma……Y N
Rheumatic fever……Y N
Headaches……Y N
Ulcers……Y N
Head/Neck Trauma……Y N
Seizures……Y N
Kidney Disease……Y N
Fibromyalgia……Y N

Have you or any immediate family member ever been told you have (Circle **Y**es or **N**o):

| | **Self** | | **Family** | |
|---|---|---|---|---|
| Cancer…… | Y | N | Y | N |
| Stroke…… | Y | N | Y | N |
| Diabetes…… | Y | N | Y | N |
| Osteoporosis…… | Y | N | Y | N |
| High Blood Pressure…… | Y | N | Y | N |
| Osteoarthritis…… | Y | N | Y | N |
| Heart Disease…… | Y | N | Y | N |

Are you taking any medications? Y N
If yes, which ones? _____

_____

Are you taking any vitamins or supplements? Y N
If yes, which ones? _____

_____

Do you or have you in the past smoked tobacco? Y N
If yes, _____ packs, _____ years
Last tobacco use: _____
How many alcoholic drinks do you routinely have per week?
# _____ per week

## Present Symptoms

**List the symptoms you're experiencing today from most severe (1) to least severe (3):**

1. _____
□ 1 (mild) □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □10 (severe)
*Type of pain:* □ sharp □ dull □ ache □ numb □ burning
□ stiff □ shooting □ tingling □ throbbing □ stabbing
*How often do you feel this?* □ constant □ daily □ off & on
□ weekly □ monthly □ other _____
How did it begin?_____
Is it getting: □ better □ worse □ same
What makes it better: _____
What makes it worse: _____

2_____
□ 1 (mild) □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □10 (severe)
*Type of pain:* □ sharp □ dull □ ache □ numb □ burning
□ stiff □ shooting □ tingling □ throbbing □ stabbing
*How often do you feel this?* □ constant □ daily □ off & on
□ weekly □ monthly □ other _____
How did it begin?_____
Is it getting: □ better □ worse □ same
What makes it better: _____
What makes it worse: _____

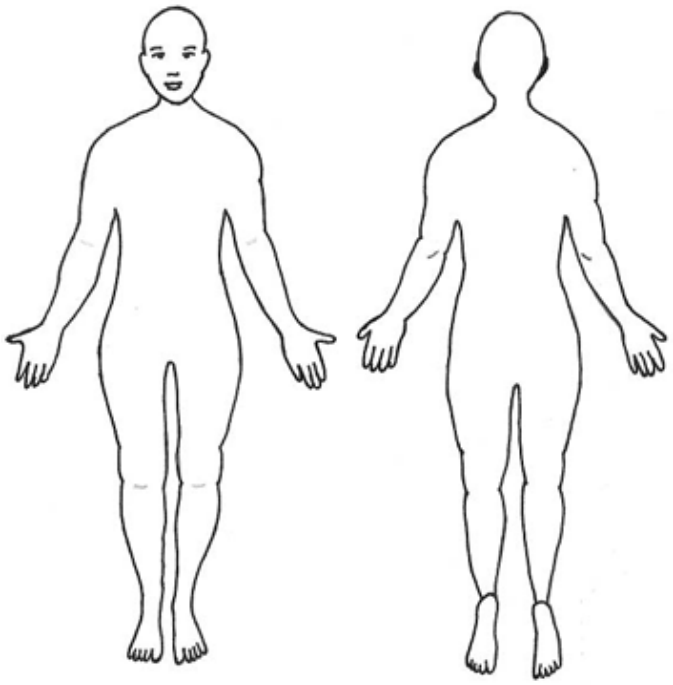
3. _____
□ 1 (mild) □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □10 (severe)
*Type of pain:* □ sharp □ dull □ ache □ numb □ burning
□ stiff □ shooting □ tingling □ throbbing □ stabbing
*How often do you feel this?* □ constant □ daily □ off & on
□ weekly □ monthly □ other _____
How did it begin?_____
Is it getting: □ better □ worse □ same
What makes it better: _____
What makes it worse: _____

## Pain Diagram

On the diagram below, please indicate where you are experiencing pain or other symptoms.

*A = Ache B = Burning N = Numb*

*S = Stabbing T = Tingling O = Other*



## Patient Health Information Privacy

We want you to know that your Patient Health Information (PHI) will only be used for the purposes of treatment, payment and coordination of care. Be assured that this office will limit the release of all PHI to the minimum needed. You have the right to examine and obtain a copy of your PHI at any time and request corrections. All staff has been trained in the area of patient record privacy. We encourage you to read the HIPAA Notice that is available to you at the front desk before signing this consent. By signing below, you understand and agree with how your records will be used.

### Acceptance as a Patient

I affirm that the information I am providing to Avon Chiropractic Clinic is accurate to the best of my knowledge. I understand that it is my responsibility to inform this office if there are any changes in my health. I agree to allow the doctor(s) and staff of this office to examine me to evaluate whether chiropractic care would be appropriate treatment for my symptoms and/or conditions. If chiropractic care is appropriate, I understand that the doctor will discuss with me the benefits, risks and alternatives before providing treatment.

**X**_____

***Signature of patient or person acting on patient's behalf***

**Date:** _____