SPRINGCREEK – COIT CHIROPRACTIC

Patient Information

Name_____ Date of Birth _____ Age _____
Address_____ City/State_____ Zip_____
Social Security #_____ D.L. #_____ Cell Phone_____
Male Female Marital Status _____ Home Phone_____
Work Phone_____ Email_____
Employer_____ Employer Address_____

Spouse's Name _____ Day time #_____
Spouse's Social Security # _____

Who may we thank for referring you? _____
Or how did you find us? Phone Book Drive By Advertisement Postcard
Internet Yellow Pages Internet Search Web Page Insurance Carrier Provider List

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Emergency *Name and address of person other than your spouse, that you would wish be contacted in case of emergency:*
Name_____ Home Phone_____
Work Phone_____ Cell Phone_____
Relationship to Patient _____

Insurance
Policy Holder's Name _____
Insured's Employer _____
Insurance Company _____
Relationship to Patient _____
Policy Holder Date of Birth_____ ID/Policy #_____

Do you have a Health Savings Account? _____ Yes _____ No

Is your present problem due to an injury? Yes No On the Job Auto Collision Personal Injury
Have you made a report of your accident? Yes No To Employer Auto Carrier Other _____
Are you now or have you ever been disabled/impaired? (Service or Work?) Yes No
When? _____
Have you retained an attorney? Yes No Name and Address and Phone _____
_____

Assignment of Benefits

I authorize payment of any medical benefits be paid directly to Janet D. Pitts, D.C., P.A. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services. I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services and products received. I understand that I will also be responsible for all collection and interest fees of 10% and/or attorney fees for non payment of account.

Patient's Signature_____ Date_____
Guardian Signature_____ Date_____

SPRINGCREEK-COIT CHIROPRACTIC
Primary Complaint History

Patient Name_____ Date_____
Describe your Symptoms:_____
_____
_____
When did your symptoms start? _____
How did your symptoms begin? _____
Have you received care for this condition from other doctors? _____If yes, who did you see?_____
What treatment did you receive and when? _____
_____
What tests have you had for your symptoms and when were they performed? _____
☐ X-Rays date_____ ☐ MRI date_____ ☐CT Scan date_____ ☐ Other_____

Occupation _____ Shift 1 2 3 Job Description _____
Are you aware of any specific event that may have caused this problem?_____
Is this problem related to ☐ Auto Collision ☐ Injury ☐ Work
What makes your symptoms worse? _____
What makes your symptoms better? _____
Is pain better or worse depending on time of day? Describe: _____

How often do you experience your symptoms?
☐ Constantly (75%-100% of the day) ☐ Frequently (51%-75% of the day)
☐ Occasionally (26%-50% of the day) ☐ Intermittently (0-25% of the day)

Have you had similar symptoms in the past?
☐ Yes ☐ No

How are your symptoms changing?
☐ Getting better ☐ Not changing ☐ Getting worse

How much of the time does your condition interfere with social activities?
☐ All the time ☐ Most of the time ☐ Sometimes ☐ A little bit ☐ None

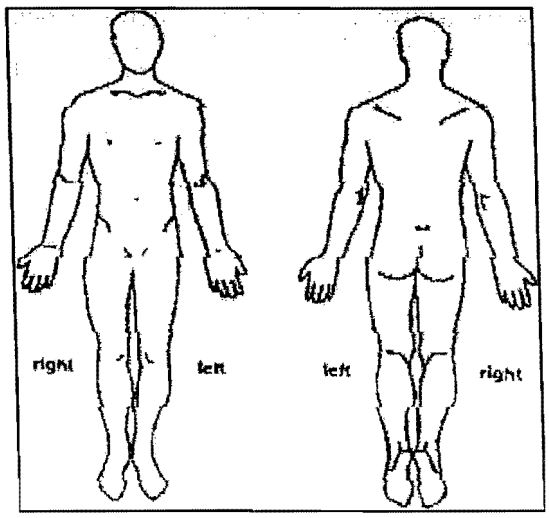
How much has pain interfered with your daily activities?
☐ Not at all ☐ a Little bit ☐ Moderately
☐ Quite a bit ☐ Extremely

You would say your overall health right now is.....
☐ Excellent ☐ Very Good ☐Good
☐ Fair ☐Poor

LIST all PRESCRIPTION, OVER THE COUNTER or HERBAL medication you are taking for this problem?
PAIN KILLER(S):_____
MUSCLE RELAXERS: _____
NERVE PILLS: _____
OTHER: _____

Describe the type of pain you are experiencing by checking all boxes that apply and indicate area involved:
☐ Pins and Needles _____ ☐ Burning _____ ☐ Ache _____
☐ Muscle Spasm _____ ☐ Stabbing _____ ☐ Numbness _____
☐ Tenderness _____ ☐ Radiates _____

MARK THE AREA WHERE YOUR PAIN OCCURS:



RATE THE AVERAGE INTENSITY OF YOUR SYPMTOMS :
by circling a number on a scale from 1 to 10.

10 = Extreme pain. You should be in hospital.
7, 8, 9 = Severe pain that prevents you from taking care of yourself. You are dependent on others.
4, 5, 6 = Moderate pain that prevents you from doing some daily activities.
1, 2. 3 = Mild pain that is uncomfortable, but you are still able to continue with daily activities.

AREA OF COMPLAINT	RATING
_____	1 2 3 4 5 6 7 8 9 10
_____	1 2 3 4 5 6 7 8 9 10
_____	1 2 3 4 5 6 7 8 9 10

SPRINGCREEK-COIT CHIROPRACTIC
Health History

Patient Name _____ Date _____

Major Surgery Circle those that apply:
Appendix Gall Bladder Neck Heart Back Leg Hernia

Date of Surgery: _____
Other Surgeries: _____
Major Accidents or Falls/Date _____
Hospitalizations other than above _____
Previous Chiropractic Care/ Date / Dr. _____
Have you been treated for any other health conditions in the last year? If yes, explain _____

Please indicate if you have been diagnosed with any of the following:

Rheumatoid Arthritis	Cancer	Poor Circulation	Liver Disease/Jaundice	Allergies	Diabetes
Osteoarthritis	Stroke	Depression	Multiple Sclerosis	Lupus	Kidney Disease
Immune Deficiency	Guillian Barre	Convulsions	Osteoporosis	Shingles	Gout
Heart Problems	Hepatitis	Prostate Problems	Gall Bladder Problems	Fibromyalgia	
High Blood Pressure	Scoliosis	Herniated Disk	Spinal Stenosis	Chronic Fatigue Syndrome	

Please indicate if you are having or recently had (in last week) any of these symptoms:

Fever, Chills	Loss of Function or	Chest Pain	Difficulty Urinating	Frequent Urination
Sudden Weight Loss	Numbness of part or	Slurred Speech	Leg or Arm Weakness	Bruise Easily
Difficulty Breathing	all of an Arm or Leg	Difficulty Walking	Blood in Urine or Feces	Swelling Ankles
Urinary Control Loss	Pain on Urination	Dizziness	Vomiting/Nausea	Night Sweats
Frequent Colds/Flu	Abdominal Pain	Neck Pain	Chronic Cough	Hot Flashes
Nose Bleeds	Loss of Sleep	Low Back Pain	Excess Period Flow	Painful Periods
Tremors	Warm/Swollen Joints	Mid Back Pain	Gas/Bloating/Belching	Constipation
Hip Pain	Pain when walking	Headache	Abdominal Bloating	Pain when sitting

Family History

Parents: Living
Deceased

_____

Siblings (#) _____
Family Healthy? Yes No
Family Health Problems:
Cancer _____
Diabetes _____
Digestive Problems _____
Heart Problems _____
Arthritis _____
Back Problems _____
Psychological _____
Neurological _____
Other _____

Sleep Habits

Hours per night: _____
Continuous? Y N
If no, what wakes you?
_____
_____
Mattress age? _____
What position do you sleep in? _____

Sleeping Pills? Y N
Pillow? Feather or Foam
Concerns: _____
_____
_____
_____

General Lifestyle

Diet Rating: Poor 1 2 3 4 5 Healthy
(Healthy diet is balanced, with whole foods of all types and varieties, avoiding processed foods and eating lots of fruits and veggies).
Alcohol (drinks/day) _____
Coffee/Tea (cups/day) _____
Tobacco (packs/day) _____
Recreational Drugs Yes No
Soft Drinks (#/day) _____
Artificial Sweeteners _____
Allergies _____
_____

Exercise : Do you get regular exercise?
_____
_____

Have you ever had a bone density test or a bone density screening examination? Yes No
If yes; **when**? _____ **where**? health fair hospital doctor's office
other (explain) _____

LIST all other PRESCRIPTION, OVER THE COUNTER or HERBAL medication you are taking for other conditions.?
_____
_____
_____
_____
_____

Multi-vitamin (what brand) _____
Birth Control Pills Hormone Replacement Therapy Daily Aspirin