



# ROCKY RIDGE

chiropractic care center

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards.

Please print clearly.

Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_ Age \_\_\_\_\_  M  F

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Marital Status  Single  Divorced  Widow  Married

Spouse's Name \_\_\_\_\_ Spouse's DOB \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

If you have seen a chiropractor in the past, please provide following information.

When \_\_\_\_\_ Whom \_\_\_\_\_

**CONTACT INFORMATION** (Please check preferred method of contact)

Home Phone  \_\_\_\_\_ Work Phone  \_\_\_\_\_ Cell Phone  \_\_\_\_\_

**EMPLOYMENT**

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**INSURANCE INFORMATION**

(if you are not the primary policy holder, we will need the primary holder's date of birth for process)

Primary Card Holder's Name \_\_\_\_\_ Primary DOB \_\_\_\_\_

Relationship to Primary \_\_\_\_\_ Who is responsible for this account? \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

Contract/Policy # \_\_\_\_\_ GRP \_\_\_\_\_



**REASON FOR VISIT**

**1. Area that has prompted me to seek care today:**

	HEADACHE		SHOULDERS		MID BACK		HIPS
	NECK		ARMS/HANDS		LOWER BACK		LEGS

**2. Check all that apply:**

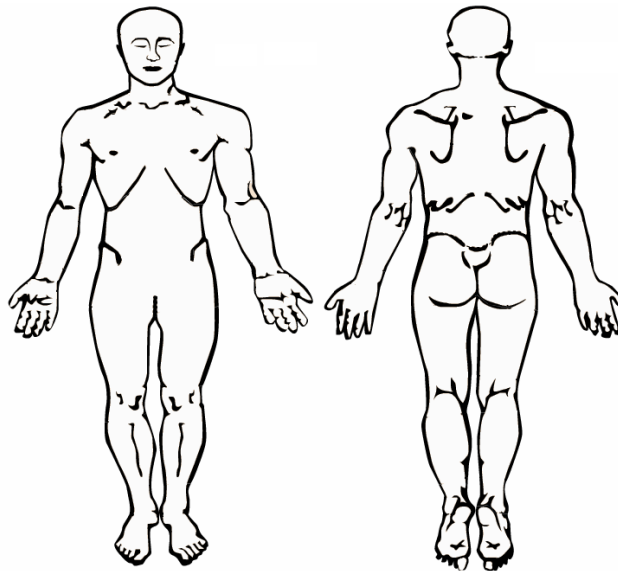
	NUMBNESS		STIFFNESS		ACHING
	TINGLING		DULL		CRAMPS
	NAGGING		BURNING		THROBBING
	SHARP		SHOOTING		STABBING

Other Symptoms: \_\_\_\_\_

2A. Onset (When did you first notice your current symptoms?) \_\_\_\_\_

2B. Location: (Where does it hurt?)

Please Circle Painful Area



**3. Intensity** (how extreme are your current symptoms?) Please circle one

1 2 3  
    
 Absent

4 5 6  
    
 Moderate

7 8 9 10  
     
 Agonizing

**4. Which word best describes the frequency of your discomfort?**

Constant     Intermittent     Occasional     Rare



**5. Which phrase best describes *changes* in your discomfort during the day? (select one)**

- It is worse in the morning  It is worse in the afternoon  It is worse at night  
 It changes with the weather  It does not change

**6. What helps with your discomfort? (select all applicable)**

- Ice  Heat  Medication  Nothing helps  Other: (describe) \_\_\_\_\_

**7. Does pain radiate to other areas? If so, Where? \_\_\_\_\_**

**6. What activities are limited by your discomfort? (Select all applicable)**

- Bending  Driving  Pulling  Sleeping  Urinating  Bowel Movement  Getting up  Pushing  
 Sneezing  Walking  Coughing  Lifting  Reading  Standing  Working  Daily Routine  
 Lying down  Sitting  Turning my head

**7. How does the pain interfere with:**

- A. Work or Career: \_\_\_\_\_  
B. Recreational: \_\_\_\_\_  
C. Household: \_\_\_\_\_  
D. Personal Relationships: \_\_\_\_\_

**8. Please list surgeries and / or fractures:**

\_\_\_\_\_  
\_\_\_\_\_

**9. What else should the doctor know regarding your current condition? \_\_\_\_\_**

\_\_\_\_\_



## **Medical History**

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please mark any conditions that you may have had in the past or currently have:

### **Musculoskeletal:**

	TMJ Issues		Scoliosis		Arthritis		Knee Injury
	Muscle Cramps		Sciatica		Herniated Disk		Numbness or Tingling in Feet
	Muscular Dystrophy		Arthritis		Pinched Nerve		Numbness or Tingling in Hands
	Foot/Ankle Injury		Shoulder Injury		Elbow/Wrist Pain		Joint Pain

### **Respiratory:**

	Asthma		Apnea		Emphysema		Pneumonia
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### **Cardiovascular:**

	High Blood Pressure		Low Blood Pressure		High Cholesterol		Poor Circulation
	Swelling of ankles		Slow Heartbeat		Rapid Heartbeat		Palpitations
	Angina		Excessive Bruising				

### **Digestive:**

	Ulcers		Food Sensitivity		Heartburn		Constipation
	Bloated Abdomen		Colitis		Gallbladder Trouble		Hernia
	Crohn's Disease		Diverticulosis		IBS Irritable Bowel Syndrome		

### **Genitourinary:**

	Kidney Stones		Prostate Issues		Infertility		Bladder Infection
	PMS Symptoms		UTI (Urinary Tract Infection)				Gout

### **Endocrine:**

	Thyroid Issues		Immune Disorder		Hypoglycemia		Low Energy
	Frequent Infection		Swollen Glands		Diabetes		

### **Skin:**

	Skin Cancer		Psoriasis		Eczema		Acne
	Hair Loss		Shingles		Hives or Allergies		Varicose Veins



**Medical History Cont.**

**Sensory:**

	Blurred Vision		ringing of Ears		Chronic Ear Infection		Hearing Loss
	Loss of Taste		Sinusitis				

**Constitutional:**

	Fainting		Low Libido		Poor Appetite		Fatigue
	Sudden Weight Gain/Loss				Weakness		Insomnia

**Other:**

	Anxiety		Depression		Headache		Vertigo
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Autoimmune Disorder (What type):

\_\_\_\_\_

**Prescription Medication:**

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_



## **ACKNOWLEDGEMENTS**

To set clear expectations, improve communication and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

\_\_\_\_\_ I instruct the chiropractor to deliver the care that, in his professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered at this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

\_\_\_\_\_ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

\_\_\_\_\_ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters emails or health information to me as an extension of my care in this office.

\_\_\_\_\_ I grant permission for submission of my visits to my insurance carrier. I acknowledge that any insurance I may have is an agreement between the carrier and me. I am responsible for the payment of any covered or non-covered service I may receive.

\_\_\_\_\_ I acknowledge to the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

\_\_\_\_\_ I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of my last menstrual period (MM/DD/YYYY) \_\_\_\_\_

If patient is a minor, print child's full name \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date