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 _____ Legal First Name _____

Birth Date _____ Preferred Name (Optional) _____ Age _____ M or F (circle)

Address _____

City _____ State _____ Zip _____

Email _____

Marital Status Single Divorced Widow Married (circle one)

Spouse's Name _____ Spouse's DOB _____

Whom may we thank for referring you? _____

Have you seen a chiropractor previously? Y or N

If Yes: 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:

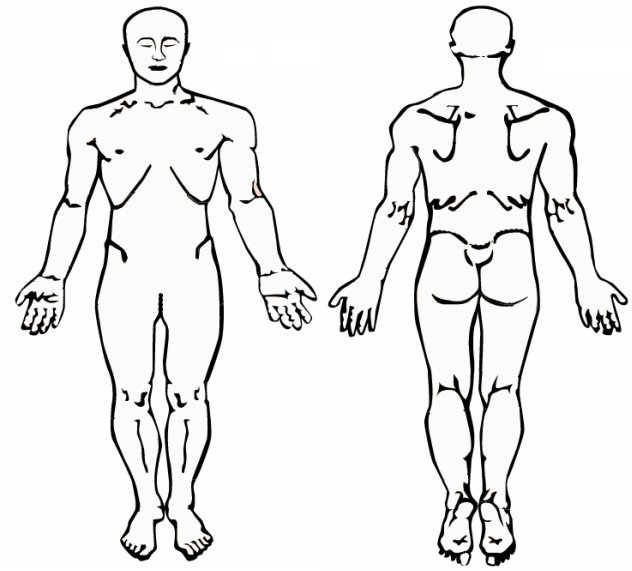
	NUMBNESS		STIFFNESS		ACHING
	TINGLING		DULL		CRAMPS
	NAGGING		BURNING		THROBBING
	SHARP		SHOOTING		STABBING

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	4 5 6	7 8 9 10
Absent	Moderate	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? Y or N 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		Herniated Disk		Knee Injury
	Muscle Cramps		Sciatica		Pinched Nerve		Numbness or Tingling in Feet
	Muscular Dystrophy		Arthritis		Elbow/Wrist Pain		Numbness or Tingling in Hands
	Foot/Ankle Injury		Shoulder Injury		Joint Pain		Other

Respiratory:

	Asthma		Apnea		Emphysema		Pneumonia

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

Autoimmune Disorder (What type):

_____

Prescription Medication:

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

Have you previously been exposed to COVID19 or currently experiencing any symptoms?

Y or N (CIRCLE)

Current Symptoms? _____

Date of exposure? _____

Date of most recent test? _____

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