



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:

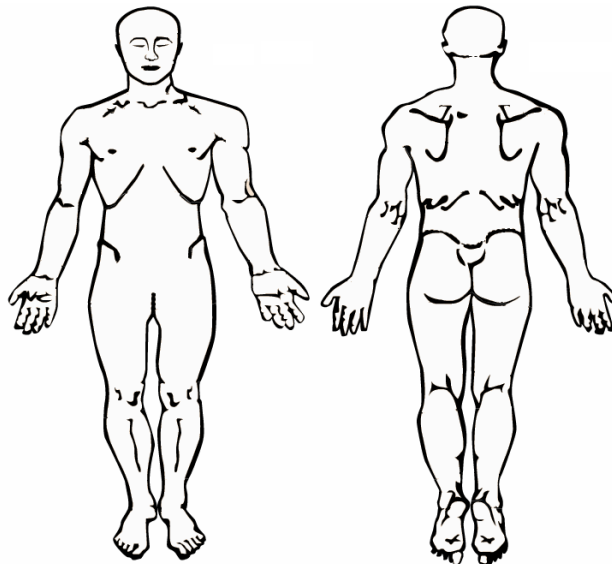
	NUMBNESS		STIFFNESS		ACHING
	TINGLING		DULL		CRAMPS
	NAGGING		BURNING		THROBBING
	SHARP		SHOOTING		STABBING

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:

<input type="checkbox"/>	TMJ Issues	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	Herniated Disk	<input type="checkbox"/>	Knee Injury
<input type="checkbox"/>	Muscle Cramps	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	Pinched Nerve	<input type="checkbox"/>	Numbness or Tingling in Feet
<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Elbow/Wrist Pain	<input type="checkbox"/>	Numbness or Tingling in Hands
<input type="checkbox"/>	Foot/Ankle Injury	<input type="checkbox"/>	Shoulder Injury	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	Other

Respiratory:

<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Apnea	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Pneumonia
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Cardiovascular:

<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Poor Circulation
<input type="checkbox"/>	Swelling of ankles	<input type="checkbox"/>	Slow Heartbeat	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	Angina	<input type="checkbox"/>	Excessive Bruising	<input type="checkbox"/>		<input type="checkbox"/>	

Digestive:

<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Food Sensitivity	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Bloated Abdomen	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	Gallbladder Trouble	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	Diverticulosis	<input type="checkbox"/>	IBS Irritable Bowel Syndrome	<input type="checkbox"/>	

Genitourinary:

<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	Prostate Issues	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	Bladder Infection
<input type="checkbox"/>	PMS Symptoms	<input type="checkbox"/>	UTI (Urinary Tract Infection)	<input type="checkbox"/>		<input type="checkbox"/>	Gout

Endocrine:

<input type="checkbox"/>	Thyroid Issues	<input type="checkbox"/>	Immune Disorder	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	Low Energy
<input type="checkbox"/>	Frequent Infection	<input type="checkbox"/>	Swollen Glands	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	

Skin:

<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Acne
<input type="checkbox"/>	Hair Loss	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	Hives or Allergies	<input type="checkbox"/>	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):

Nutritional Supplements and Herbs:

Supplement: _____ Times per Day: _____

Supplement: _____ Times per Day: _____

Supplement: _____ Times per Day: _____

Supplement: _____ Times per Day: _____

Supplement: _____ Times per Day: _____

List any additional comments and/or routines on back*

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 underlying 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

Rocky Ridge Chiropractic Care Center

NO SHOW / CANCELLATION ACKNOWLEDGEMENT

Print Name: _____ DOB: _____

Cell Number: _____ E-mail: _____

I acknowledge the following:

- It is important to show up on time for my appointment, and this facility has the right to cancel my appointment if I run late.
- I understand that appointment reminders are a courtesy service. I will provide an e-mail address and/or cell number to receive the appointment reminders. However, I may not always get a reminder due to unforeseen circumstances and should not rely on them solely.
- If a follow-up appointment is recommended by my provider and I do not show up, it may affect my healing process and time frame.
- If I do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient.
- It is important that I notify (either by e-mail/text/calling) my doctor's office at least 24 hours in advance when I need to cancel or reschedule an appointment. If I am unable to give a 24-hour notification of cancellation, I will be charged a \$25 no-show fee. Upon scheduling an appointment, a credit card number will be required to keep on file.
- For personal injury patients, the fee is collected from the patient and not billed towards an open claim or attorney.
- This facility may choose to terminate me from the practice if I have more than 2 no-show occurrences or fail to acknowledge this policy.

Signature of Patient / Legal Guardian / Responsible Party

Date

Printed Name of Legal Guardian / Responsible Party

Date