Richland Chiropractic Center

DR. CHAD R. ESPELAND

Phone: 936-6940
BY APPOINTMENT

1201 Hwy. 49 South
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Richland, MS 39218

Name_____ Sex: M F
Address _____Apt. _____
City _____ State_____ Zip_____
Home Phone #_____ D.O.B._____ Age_____
Cell Phone # _____ Cell Carrier _____
SS# _____ D. L. #_____
Marital Status: M S D W Sep. Height ____' ____" Weight _____ lbs.
E-mail _____ Occupation_____
Employer_____WorkPhone #_____Ext._____

IN CASE OF EMERGENCY, CONTACT_____
Phone #(H)_____(W)_____Relationship_____
Address_____
City_____ State_____ Zip_____
Referred to this office by _____
Nearest relative(not living with you) Name _____
Address _____
City, State, Zip_____

Electronic Communication Policy

We would like to contact you via emails and/or text messages for certain office communication, such as appointment reminders, office closings, etc. In accordance with HIPAA protocols, this provides us with the permission to contact you by the method(s) of your choice.

Please mark only one (1) answer:

_____ I give my permission to receive text messages **and** email communications.
_____ I give my permission to receive text messages, **but** not email communications.
_____ I give my permission to receive email communications, **but** not text messages.
_____ I do not want to receive text messages or emails.

Signature: _____ Date: _____

FOR OFFICE USE ONLY:

File #_____

Name(Print): _____ Date: _____

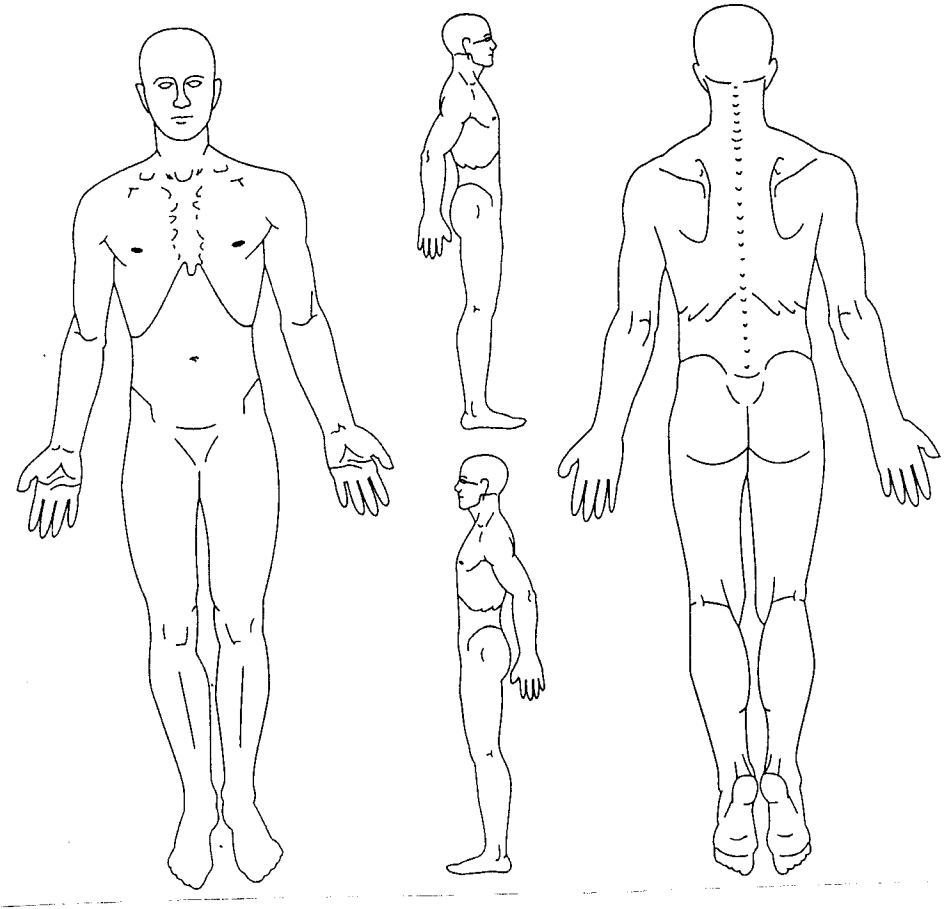
PATIENT PROBLEM/CONDITION

Is condition due to an accident? Y N If yes, date_____
Type of accident: Auto Work Home Other_____
Describe your problem or condition_____
_____
_____
_____

When did your problem/condition start? Date_____
How did your problem/condition start? Gradual Sudden Unknown
Is your problem/condition getting worse over time? Yes No Unknown
Type of pain: Sharp Throbbing Stabbing Achy Shooting Annoying
Burning Tingling Dull Pounding Pulsating Pinching
How often do you have this pain? 25% (intermittent) 50% (occasional) 75% (frequent) 100% (constant) of the time.
What time of day is the pain the worst: Morning Afternoon Evening Night
What time of day is the pain the least: Morning Afternoon Evening Night
How intense is the pain on a scale of 1(no pain) to 10(severe pain)?_____
Does the problem/condition interfere with: Work Sleep Activities around house Exercise Social Activities Hobby
Is there anything that makes your pain better? _____
Is there anything that makes your pain worse? _____
Have you ever had a similar problem to the one you are currently experiencing? Y N
If yes, how many times has the problem/condition bothered you in the past? _____
What treatment have you tried for this problem/condition? OTC medications Rx medications Chiropractic
Physical therapy Injections Surgery None Other_____
Please circle and give date if you have had any of the following for the problem you are experiencing?: MRI_____
Myelogram_____ X-rays_____ Bone Scan_____ CT scan_____
Name of doctors that have treated you for this problem/condition:_____
Have you ever had chiropractic care? Y N If yes, how long ago_____

Please use the symbols below to show the area, upon the body outlines, in which you are experiencing symptoms.

A = Ache
B = Burning
N = Numbness
P = Pins/Needles
S = Sharp/Shooting
O = Other



REVIEW OF SYSTEMS: Circle Yes (Y) or No (N):

Constitutional			**Respiratory**			**Gastrointestinal**			**Dermatology**		
Recent weight loss	Y	N	Cough	Y	N	Abdominal pain	Y	N	Rashes	Y	N
Fever	Y	N	Wheezing	Y	N	Heartburn	Y	N	Sores	Y	N
Chills	Y	N	Short of breath	Y	N	Bloody stool	Y	N	Blisters	Y	N
									Dry or sensitive skin	Y	N
Endocrine			**Allergy**			**Psychology**			Hives	Y	N
Excessive thirst	Y	N	Runny nose	Y	N	Depression	Y	N	Suspicious moles	Y	N
Excessice sweating	Y	N	Itchy eyes	Y	N	Mood swings	Y	N	Suspicious lesions	Y	N
Excessive urination	Y	N	Stuffy nose	Y	N	Anxiety	Y	N	Itching	Y	N
Urology			**ENT**			**Genitourinary (Female)**			**Hematologic/Lymphatic**		
Frequent urination	Y	N	Nose bleeds	Y	N	Pelvic pain	Y	N	Easy bruising	Y	N
Difficulty urinating	Y	N	Sore throat	Y	N	Irregular periods	Y	N	Swollen glands	Y	N
Blood in urine	Y	N	Change in voice	Y	N	Recurrent infections	Y	N	Fatigue	Y	N
Cardiology			**Ophthalmology**			**Musculoskeletal**			**Neurology**		
Palpitations	Y	N	Eye irritation	Y	N	Muscle aches	Y	N	Dizziness	Y	N
Chest pains/tightness	Y	N	Blurred vision	Y	N	Joint pain	Y	N	Headaches	Y	N
High blood pressure	Y	N	Eye drainage	Y	N	Joint swelling	Y	N	Seizures	Y	N
Varicose veins	Y	N	Visual changes	Y	N	Joint stiffness	Y	N	Weakness	Y	N

FAMILY HISTORY: Does anyone in your family have a history of diabetes, rheumatoid arthritis, heart problems, stroke, cancer or multiple sclerosis?_____

_____

Has anyone in your family ever had a spine problem similar to the one you a currently experiencing? Please circle

Mother Father Sister Brother Grandmother Grandfather

List **ALL** prescription and over-the-counter medications you are currently taking_____

_____

Past surgeries_____

Past fractures/dislocations_____

Past car accidents_____

Past traumas_____

List **ALL** allergies_____

EXERCISE	**WORK ACTIVITY**	**HABITS**	
None	Sitting	Smoking	Packs/day_____
1-3 x / wk	Standing	Alcohol	Drinks/wk_____
4-6 x / wk	Light Labor	Coffee/Caffeine Drinks	Cups/Day_____
Daily	Heavy Labor	High Stress Level	Reason_____

I authorize payment to Richland Chiropractic Center. Richland Chiropractic Center may use and share your health information without your written authorization, for activities relating to treatment, payment, and health care operations. I have received a copy of the Notice of Privacy & Patient Rights for the Richland Chiropractic Center.

*Signature*_____ *Date*_____

Doctor comments/notes: _____

_____

_____

_____

BCBS BCBS State UHC Aetna Cigna Medicare Medicare/COB Humana Medicare/Medicaid

Medicaid Magnolia/United Ambetter CHIPS Self Pay Other_____

SYMPTOMS LIST: Please check any symptoms you have from the list below.

Your Name: _____ Date: _____

HEAD:
- ____1. Headache
- ____2. sinus (allergy)
- ____3. entire head
- ____4. back of head
- ____5. forehead
- ____6. temples
- ____7. migraine
- ____8. frequent and severe
- ____9. Head feels heavy
- ____10. Lightheadedness
- ____11. Fainting
- ____12. Face flushed
- ____13. Loss of memory
- ____14. Eye strain
- ____15. Light bothers eyes
- ____16. Blurred vision
- ____17. Double vision
- ____18. Loss of vision
- ____19. Loss of balance
- ____20. Dizziness
- ____21. Loss of hearing
- ____22. Pain in the ears
- ____23. Ringing in the ears R L
- ____24. Buzzing in the ears R L
- ____25. Loss of taste
- ____26. Loss of smell
- ____27. Sinus trouble

NECK:
- ____30. Neck pain
- ____31. Neck stiffness
- ____32. Neck pain and stiffness
- ____33. Moderate to severe neck pain
- ____34. Neck pain with movement
  - ____35. forward
  - ____36. backward
  - ____37. turning to the left
  - ____38. turning to the right
  - ____39. bending to the left
  - ____40. bending to the right
- ____41. Pinched nerve in the neck
- ____42. Neck feels "out of place"
- ____43. Muscle spasms in the neck
- ____44. Grinding sounds in the neck
- ____45. Arthritis in the neck

SHOULDERS:
- ____50. Pain in shoulder joint R L
- ____51. Pain across shoulders
- ____52. Pain between shoulder blades
- ____53. Stiffness in shoulder R L
- ____54. Tension in the shoulders
- ____55. Pinched nerve - shoulder R L
- ____56. Muscle spasms - shoulder R L
- ____57. Unable to raise arm R L
  - ____58. above shoulder level R L
  - ____59. over head R L

ARMS & HANDS:
- ____65. Pain in the upper arm R L
- ____66. Pain in the elbow R L
- ____67. Tennis elbow R L
- ____68. Pain in forearm R L
- ____69. Pain in hands R L
- ____70. Pain in fingers of R L hand
- ____71. Sensation of pins & needles in the arm R L
- ____72. Sensation of pins & needles in the fingers R L
- ____73. Numbness in arms R L
- ____74. Numbness in fingers R L
- ____75. Fingers go to sleep R L
- ____76. Hands get cold
- ____77. Swollen joints in fingers
- ____78. Stiffness in fingers R L
- ____79. Loss of grip strength R L

MID-BACK:
- ____82. Mid-back pain
- ____83. Mid-back stiffness
- ____84. Mid-back pain and stiffness
- ____85. Mid-back muscle spasms
- ____86. Pain in kidney area

CHEST:
- ____90. Chest pain
- ____91. Shortness of breath
- ____92. Pain around the ribs
- ____93. Breast pain
- ____94. Irregular heartbeat

ABDOMEN:
- ____100. Nervous stomach
- ____101. Nausea
- ____102. Gas
- ____103. Constipation
- ____104. Diarrhea
- ____105. Hemorrhoids

LOW BACK:
- ____110. Low back pain
- ____111. Low back stiffness
- ____112. Low back pain and stiffness

Low back pain is worse when:
- ____114. working
- ____115. lifting
- ____116. stooping
- ____117. standing
- ____118. sitting
- ____119. bending
- ____120. coughing
- ____121. lying down (sleeping)
- ____122. walking

- ____125. Low back feels out of place
- ____126. Muscle spasms in low back

HIPS, LEGS & FEET:
- ____130. Pain in buttocks R L
- ____131. Pain in the hip joint R L
- ____132. Pain down the leg R L
- ____133. Pain down both legs
- ____134. Leg cramps R L
- ____135. Cramps in feet R L
- ____136. Knee pain R L
  - ____137. inside R L
  - ____138. outside R L
- ____139. Pins & needles in legs R L
- ____140. Numbness of leg R L
- ____141. Numbness of feet R L
- ____142. Numbness of toes R L
- ____143. Swollen ankles R L
- ____144. Swollen feet R L
- ____145. Feet feel cold

WOMEN ONLY:
- ____150. Menstrual pain (where) _____
- ____151. Menstrual cramping
- ____152. Irregular period
- ____153. Abnormal discharge
- ____155. Tumors

MEN ONLY:
- ____160. Urinary frequency
- ____161. Difficulty in starting urination
- ____162. Night urination
- ____163. Prostate pain/swelling

GENERAL:
- ____170. Anxiety
- ____171. Nervousness
- ____172. Irritable
- ____173. Difficulty in prolonged riding in an automobile
- ____174. Depression
- ____175. Fatigue
- ____176. Generally feel run down
- ____177. Difficulty sleeping
- ____178. Loss of weight _____lbs.
- ____179. Gain weight _____lbs.
- ____180. Excessive perspiration
- ____181. Pallor
- ____182. Tremors

Write in your own symptoms: _____