Patient Name_____ Birthdate _____ Age _____ Sex: M / F

dress _____ City _____ State _____ Zip _____

rnone ( )_____ Occupation_____ Employer_____ _____

Cell Phone _____ Soc. Sec#_____ Height _____ Weight _____

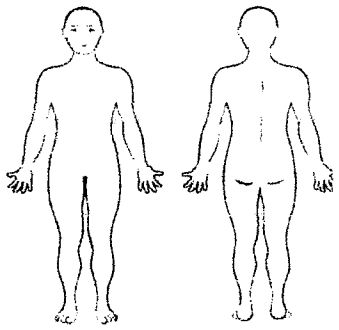
Insurance _____ *Marital Status* ____ *Spouse's Name* _____ *Spouse D.O.B.* _____ _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. Email :_____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

o Headache o Neck Pain o Mid-Back Pain o Low Back Pain

o Other _____

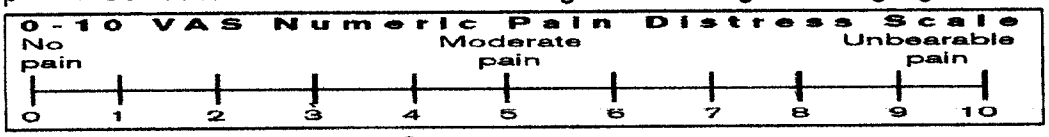


Is this? o Work Related o Auto Related o N/A

Date Problem Began _____ How Problem Began_____

What describes the nature of your symptoms?

o Sharp o Dull ache o Numb o Shooting o Burning o Tingling



How often are your symptoms present?

(Occasional) o 0 - 25% o 26 - 50% o 51 - 75% o 76 - 100% (Constant)

In general would you say your overall health right now is:

o Excellent o Very Good o Good o Fair o Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? NO YES

Date(s) taken _____ What areas were taken? _____

ease check all of the following that apply to you:

- ◯ Alcohol/Drug Dependence
- ◯ Recent Fever
- ◯ Diabetes
- ◯ High Blood Pressure
- ◯ Stroke (Date) _____
- ◯ Corticosteroid Use (Cortisone, Prednisone, etc.)
- ◯ Taking Birth Control Pills
- ◯ Dizziness/Fainting
- ◯ Numbness in Groin/Buttocks
- ◯ Cancer/Tumor (Explain) _____
- ◯ Osteoporosis
- ◯ Epilepsy/Seizures
- ◯ Other Health Problems (Explain) _____
- ◯ Prostate Problems
- ◯ Menstrual Problems
- ◯ Urinary Problems
- ◯ Currently Pregnant, # Weeks _____
- ◯ Abnormal Weight o Gain o Loss
- ◯ Marked Morning Pain/Stiffness
- ◯ Pain Unrelieved by Position or Rest
- ◯ Pain at Night
- ◯ Visual Disturbances
- ◯ Surgeries _____
- ◯ Tobacco Use - Type _____
- ◯ Frequency _____/Day
- ◯ Medications _____

Family History: o Cancer o Diabetes o High Blood Pressure o Heart Problems/Stroke o Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate; or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my Physician if my condition needs be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary. The HIPPA was provided.

Patient Signature _____ **Date** _____

3-x-17

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 are 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/Snuff	Packs or cans/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 Brown Chiropractic Center. Brown 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 Brown 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_____