STEVENS CHIROPRACTIC
& ACUPUNCTURE CLINIC

Confidential Patient Information

Today's date: _____

Name _____ Birth Date _____ Age _____

Address _____ City _____ State _____

Zip Code _____ Home Phone _____ Cell Phone _____

Social Security # _____ E-mail _____ Sex M F

Occupation _____ Employer _____

As some conditions have a higher incidence in certain races or ethnic groups, what is your predominate race or ethnic background?

(Circle one) Caucasian Black or African America Native American Hawaiian Asian Hispanic Decline specify

Single_____ Married _____ Divorced _____ Widowed _____ Name of Spouse _____

If a minor, printed name and signature of parent/guardian _____

Who referred you to our office? _____ **Give insurance card to receptionists if have not done so**

If you are not the primary insured/policy holder you must supply the following:

Name and birth date of Primary Insure or Policy Holder _____

Address of Primary Insured, if different _____ City and State _____ Zip _____

Relationship to patient: _____ Employer _____

My Signature verifies that all information supplied is true and hereby instructs and authorizes the Stevens Chiropractic Clinic, staff and employees to release any information, pertinent to my insurance claims to any insurance company or adjuster, and hereby releases the Stevens Chiropractic Clinic, staff and employees from any consequence thereof. I further authorize that a photocopy or fax of this agreement be considered as valid as the original.

I acknowledge it is my responsibility to verify what services may or may not be covered by my insurance. I assume the responsibility for full payment of my spouse or dependent's charges as well as my own which may include copays, deductibles, co-insurance if all or part of my services are not covered for any reason.

X Sign Name Here _____ **Print Name Here** _____

Medical History (*Circle if it is a present condition* and put an "X" in front of it if it is a past condition)

___ ALS / Lou Gehrig's disease
___ Alcohol dependency
___ Arthritis
___ Arthritis (Rheumatoid)
___ Angina
___ Alzheimer's disease
___ A-Fib
___ Anxiety
___ Bed wetting
___ Bladder Infections
___ Bladder stones
___ Blood clots
___ Bone spurs
___ Crohn's disease
___ Chest pain
___ Cancer (describe below)
___ COPD
___ Dermatological disorder
___ Depression
___ Digestive disorders
___ Diabetes
___ Disc (describe below)
___ Drug dependency
___ Epilepsy
___ Excessive thirst
___ Emphysema
___ Fatigue (General)
___ Fainting
___ Fertility
___ Fibromyalgia
___ Fluid retention
___ Fractures (describe below)
___ Frequent urination
___ Gout
___ Genetic (describe below)
___ Headache
___ Headache (migraine)
___ Hodgkin's disease
___ High cholesterol
___ High blood pressure
___ Heart attack
___ Heart Disease (describe below)
___ Hepatitis
___ HIV/AIDS
___ Hearing problems
___ Joint stiffness/swelling
___ Kidney disorder (describe below)
___ Kidney stones
___ Loss of appetite
___ Lupus
___ Muscle Incoordination
___ Menstrual problems/pain
___ Multiple Sclerosis
___ Neurological disorder (describe below)
___ Osteoporosis
___ Osteopenia
___ Pacemaker
___ Prostate
___ Pregnancy
___ PMS
___ Restless Leg Syndrome
___ Scoliosis
___ Sciatica (R or L)
___ Shoulder Impingement (R or L)
___ Shoulder rotator (R or L)
___ Spinal Cord Injury
___ Stroke
___ Sinus problems
___ Shingles
___ Sleep disorders
___ Thyroid problems (describe below)
___ Tumor (benign) (describe below)
___ Ulcer
___ Vertigo (Dizziness)
___ Visual disturbance
___ Vison/Eye problems

Other _____

Medical History Of Your Joint Pain(s) (*Circle if it is a present condition* and put an "X" in front of it if it is a past condition)

___ Head
___ Neck
___ TMJ/Jaw (R or L)
___ Shoulder (R or L)
___ Arm (R or L)
___ Elbow (R or L)
___ Wrist (R or L)
___ Hand (R or L)
___ Finger (R or L)
___ Carpal Tunnel (R or L)
___ Upper Back (R or L)
___ Low Back (R or L)
___ Hip ((R or L)
___ Upper Leg (R or L)
___ Lower Leg (R or L)
___ Knee (R or L)
___ Ankle (R or L)
___ Arch (R or L)
___ Foot (R or L)

Other: _____

What surgeries or joint replacements have you had?

_____

_____

_____

What is your height? _____Weight _____ Past history of tobacco use? Never Current smoker chew smokeless

_____ Patient Initials

Do you perform regular exercise of any kind? ___ None ___Light ___ Moderate ___ Heavy *How times a week?* ____

List all of your allergies _____

_____

List all medications and supplements you are currently taking (photocopy of list accepted)

_____

_____

ARE YOU HERE DUE TO A RECENT ACCIDENT? **YES NO**

IF YES, **GIVE DATE OF ACCIDENT** _____ Where were you when it happened? Home Work Car Other

Briefly describe the accident _____

IF NO, what do you think caused your problem? _____

How have your symptoms changed since their start? _____ About the same _____ Worse _____ Better

Have you seen anyone else for ***these symptoms***? **No Yes** If yes, _____ MD _____ Physical Therapist _____Chiropractor

When did you see them? _____What was their diagnosis? _____

What was their treatment? _____

Circle any of the following diagnostics received: Lab work X-rays CT Scan MRI Physical Therapy Cortisone

Have you had the same or similar symptoms in the past? **NO YES** **IF YES,** who did you consult for those symptoms, and what treatment(s) did you receive at that time.

_____

Circle any of the activities that your symptoms currently interfere with:

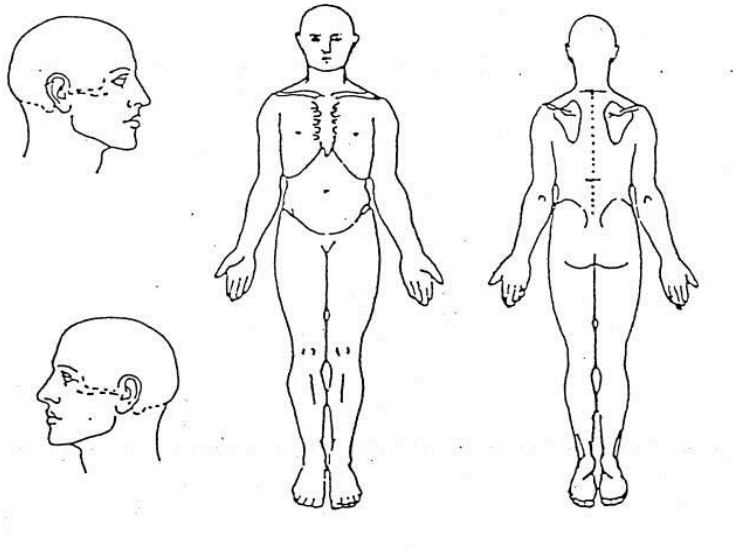
Sleeping	Twisting	Yardwork	Grasping things
Sitting	Dressing myself	Love Life	Balance
Getting out of chair	Household chores	Doing dishes	Not hungry
Rising from bed	Concentration	Standing	Turning my head
Walking	Reading	Work	Looking up
Driving	Shopping	Climbing stairs	Looking down
Bending	Exercising	Combing hair	Turning head while driving

Other: _____

_____ Patient Initials

Put a letter corresponding to the character of your symptoms and rate them 1 – 10 with a 9 or 10 requiring hospitalization. Example: You could indicate minor, but sharp pain in the neck that gets much severe at night might would have an "S" over whichever side of the neck hurt with something like a 2- 8.

P = Pain S = Sharp B = Burning T = Tingling R = Radiating D = Dull Ache
ST=Stabbing TH=Throbbing



How often do you have the neck pain? ___ 100-75% ___75-51% ___ 50-25% ___ 24-0% of the time
How often do you have the back pain? ___ 100-75% ___75-51% ___ 50-25% ___ 24-0% of the time
How often do you have the headache? ___ 100-75% ___75-51% ___ 50-25% ___ 24-0% of the time
How often do you have the other pain? ___ 100-75% ___75-51% ___ 50-25% ___ 24-0% of the time

Circle what makes your symptoms better: Rest Heat Cold Aspirin Tylenol Ibuprofen Aleve
Chiropractic Acupuncture Massage Sleep PT Meds Other: _____

Circle what makes your symptoms worse:

Sleeping	Bending	Shopping	Work
Sitting	Twisting	Exercising	Climbing stairs
Getting out of chair	Dressing myself	Yardwork	Combing hair
Getting out of bed	Household chores	Love Life	Grasping things
Walking	Concentration	Doing dishes	Balance
Driving	Reading	Standing	Sports

Other: _____

Some issues are due to heredity. Please tell us about the health of your immediate family members. Have any of them had rheumatoid arthritis, heart problems, diabetes, lupus, or cancer?

_____

_____

_____ Patient Initials