Argyle Family Chiropractic

Patient Information Sheet

Please Complete the following information below so that we may efficiently serve you.

1. **Patient Name**____
2. Address________________________City______________State____Zip__________
3. Home Phone________________________ Work Phone________________________
4. Cell Phone ________________________Birth Date______________ Martial Status_____
5. Driver's License #____________________ Soc. Sec. #________________________
6. Employment Status: Full Time__________ Part Time__________ Retired________________
7. Employer Name________________________ Occupation ________________________
8. E-mail Address__________________________________

Primary Insurance Information

1. Name of Insured________________________ Birth Date_________ Soc. Sec. #_____________
2. Address________________________ City___________________ State_____ Zip____________
3. Insurance Co.______________________ Policy #__________________ Group #_____________
4. Insurance Co. Address_____________________ City________________ State____ Zip________
5. Insured Relationship to patient: Self____ Spouse____ Child____ Other (please specify) _______________
6. Insured Employer Name____________________ Employer Address _______________________
   Employer Phone#________________________Occupation____________________________
7. Is there Secondary Insurance Coverage? Yes______ No_____ (If yes please complete next section)

Secondary Insurance Information

1. Name of Insured______________________ Birth Date___________ Soc Sec #________________
2. Address______________________ City___________________ State_____ Zip________________
3. Insurance Co.________________________ Policy #________________ Group #______________
4. Insured Co. Address______________________ City____________________ State____ Zip_______
5. Insured Relationship to Patient: Self____ Spouse_____ Child_____ Other (please specify)______________
6. Insured Employer Name__________________ Phone______________ Occupation___________

Patient Long-Term Signature Authorization

I herby authorize the release of any medical or other information necessary to process my claim.
I also request payment of government benefits either to me or to the party who accepts assignment.
I also authorize payment of medical benefits to the above provider for any services.
This authorization also permits the release of information to this provider by HCFA, its intermediaries, or carriers of unassigned Medicare Claims.
I further permit copies of this authorization to be used in place of the original.

Patient/Insured____**Date**_________________

SYMPTOMS LIST: Please check any symptoms you have had (in last 6 months) below.

Patients 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:

_____28. Neck Pain
_____29. Neck Stiffness
_____30. Neck Pain & Stiffness
_____31. Moderate to Severe Neck Pain
_____32. **Neck Pain with Movement**
_____33. Forward
_____34. Backward
_____35. Turning to the Right
_____36. Turning to the Left
_____37. Bending to the Right
_____38. Bending to the Left
_____39. Pinched Nerve in the Neck
_____40. Neck Feels "out of place"
_____41. Muscle Spasms in the Neck
_____42. Grinding Sounds in Neck
_____43. Arthritis

SHOULDERS:

_____44. Pain in Shoulder Joint R L
_____45. Pain across Shoulders
_____46. Pain between Shoulder Blades
_____47. Stiffness in Shoulders R L
_____48. Tension in the Shoulders
_____49. Pinched Nerve in Shoulder R L
_____50. Muscles Spasms in Shoulder R L
_____51. Unable to Raise Arm R L
_____52. Above Shoulder level R L
_____53. Over Head R L

ARMS & HANDS:

_____54. Pain in the Upper Arm R L
_____55. Pain in the Elbow R L
_____56. Tennis Elbow R L
_____57. Pain in the Forearm R L
_____58. Pain in the Hands R L
_____59. Over Head R L
_____60. Sensation of Pins & Needles in fingers R L
_____61. Sensation of Pins & Needles in fingers R L
_____62. Numbness in Arms R L
_____63. Numbness in Fingers R L
_____64. Fingers to Sleep R L
_____65. Hands get Cold
_____66. Swollen Joints in Fingers
_____67. Stiffness in Fingers R L
_____68. Loss of Grip Strength R L

MID-BACK:

_____69. Mid-Back Pain
_____70. Mid-Back Stiffness
_____71. Mid-Back Pain & Stiffness
_____72. Mid-Back Muscle Spasms
_____73. Pain in Kidney Area

CHEST:

_____74. Chest Pain
_____75. Shortness of Breath
_____76. Pain in the Ribs
_____77. Breast Pain

ABDOMEN:

_____79.Nervous Stomach
_____80. Nausea
_____81. Gas
_____82. Constipation
_____83. Diarrhea
_____84. Hemorroids

LOW BACK:

_____85. Low Back Pain
_____86. Low Back Stiffness

LOW BACK PAIN IS WORSE WHEN:

_____87. Working
_____88. Lifting
_____89. Stooping
_____90. Standing
_____91. Bending
_____92. Coughing
_____93. Lying Down (sleeping)
_____94. Walking
_____95. Low Back Feels Out of Place
_____96. Muscle Spasms in

HIPS, LEGS, & FEET:

_____97. Pain in Buttocks R L
_____98. Pain in the Hip Joint R L
_____99. Pain Down the Leg R L
_____100. Pain Down both Legs
_____101. Leg Cramps R L
_____102. Cramps in Feet R L
_____103. Knee Pain R L
_____104. Inside R L
_____105. Outside R L
_____106. Pins & Needles in Legs R L
_____107. Numbness of Leg R L
_____108. Numbness of Feet R L
_____109. Numbness of Toes R L
_____110. Swollen of Ankles R L
_____111. Swollen Feet R L
_____112. Feet Feel Cold

WOMEN ONLY:

____113. Menstrual Pain (when) ____________________
____114. Menstrual Cramping
____115. Irregular Period
____116. Abnormal Discharge
____117. Tumors

MEN ONLY:

____118. Urinary Frequent
____119. Difficulty in starting Urination
____120. Night Urination
_____ Uncontrolable Urination (when)_______________

Yes No **Prostrate pain/swelling**

GENERAL:

____121. Anxiety
____122. Nervousness
____123. Irritability
____124. Depression
____125. Fatigue
____126. Generally feel run down
____127. Difficulty sleeping
____128. Excessive sweating
____129. Loss of weight _______lbs.
____130. Gain in weight _______lbs.
____131. Tremors

Write in your own symptoms: _____________
____
____
____
____

Argyle Family Chiropractic

CONSULTATION HISTORY

Patient's Name: ____ Date: ____________

What have you heard about Chiropractic? ____

____

How did you hear about our office? ☐ Friend/Relative ☐ Phone book ☐ Internet ☐ Front Sign ☐ Other Add ☐ Physician Referral ☐ Other ___________

Major Complaint(s): Describe & be specific.

1. Headache ____
2. Neck Pain ____
3. Upper Back Pain ____
4. Middle Back Pain ____
5. Lower Back Pain ____
6. Extremity Problems (leg/arm/shoulder) ____
7. Other ____

Does Anyone Else in the Family Have This or Similar Problems?

Who	What Problem	Care He/She is Receiving
1.___________	1.___________	1.___________
2.___________	2.___________	2.___________
3.___________	3.___________	3. ___________

How long have you been suffering from this problem? (Major complaint)_______________

____

How often do you find yourself suffering from these problems? (Each complaint)

- (major complaint)____
- ____
- (other)____
- ____
- ____

Before you began to suffer with this, was there an earlier accident, injury or condition(s) that may or may not have been directly related to this problem? **(**Example**:** fall, auto injury, work injury, sports trauma, repetitive motion on the job.**)** ______________________________

____

____

____

Since the time you began suffering from this problem, what if anything, have you tried that did not work?(Ex: Ice, heat, rest, over-the counter meds, prescription(s), P.T., massage, other) ____
____
____

Has anything you've tried thus far, fixed your problem? ☐ Yes ☐ No
Have you become discouraged about this? ☐ Yes ☐ No
If not discouraged, what? ____
____
When this problem is at its worst, can you explain in your own words exactly what happens to you? ____
____

How does that make you feel-emotionally? ____________________________________
____

How old did you expect to be before you started experiencing these kinds of problems?
____
____
Give me an example of a day when your problem was at its worst-what happened?
____
____

Has this problem affected your (__________) YET: Describe

- Family____
- Work____
- Hobbies____

Has this problem interrupted your sleep pattern <u>yet?</u> Either **Yes** **No**

	Yes	No
1. Trouble falling asleep due to discomfort	☐	☐
2. Not enough restful sleep	☐	☐
3. Awakening in the middle of the night	☐	☐
4. Waking earlier than you normally would	☐	☐

Health History:
Previous Hospitalizations/Surgeries/Serious illnesses: ____________________________
____
When? ____

Patient social history:
Use of Caffeine: Rarely: ______ Moderate: _______ Daily: _______ Est. amount: _______
Use of alcohol: Never: ______ Rarely: ______ Moderate: ______ Daily: ______
Use of tobacco: Never______ Previously but quit: ______ Current packs / day: _______
Use of drugs: Never: ______ Recreational: ______ Type/Frequency_______________
Excessive exposure at home or work to: Fumes: ______ Dust: ______ Solvents: ______
Any other hazardous materials: ____
Medication(s) usage, (include nonprescription types): ______________________
____
____
Duration of use: ____
____

Please use the following key to accurately mark the areas in which you feel the described sensations. Use the appropriate symbols and include all affected areas.

Dull: *NNN* **Stabbing/Cutting:** *III III III* **Burning:** *XXX*
Numb: = = = **Tingling (Pins & Needles):** ***** **Cramping:** S S S

Please rate your pain using the following scale:

(0 = *No* pain & 10 = *Worst* possible pain)

(Please Circle Intensity Level)

Current pain intensity:	1	2	3	4	5	6	7	8	9	10
Average pain intensity:	1	2	3	4	5	6	7	8	9	10
Worst pain intensity:	1	2	3	4	5	6	7	8	9	10

xxxxxxxxxxxx "Mark the spaces that best describe your symptoms" xxxxxxxxxxxxx

Severity: o Mild o Mild-Moderate o Moderate o Moderate-Severe o Severe

Frequency: **o Intermediate >25% o Occasional 25-50% o Frequent 50-75% o Constant <75%**

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