WELCOME TO MOUNTAINTOP CHIROPRACTIC

PERSONAL INFORMATION

Name: ____

Address: ____

City__________________ State_____ Zip___________

Birthdate: ______________________

Marital status: __________________

Home Phone: ________________________________ Primary: YES NO

Cell Phone: _________________________________ Primary: YES NO

WOULD YOU LIKE TO RECEIVE TEXT MESSAGE APPOINTMENT REMINDERS: YES NO

Emergency Contact: ____________________________________

Are you a full-time student?: YES NO

Family Physician: _______________________________________

Name of Insurance Carrier: _______________________________

Whom may we thank for referring you?_____________________

REASON FOR VISIT

Primary reason for today's visit: ____

Is your condition caused by: AUTO ACCIDENT WORK ACCIDENT SPORT INJURY OTHER INJURY

Date your condition started:____

Describe how your condition/injury happened: ____

____

PLEASE MARK LOCATION ON DIAGRAM

P=PAIN **N=**NUMBNESS **B=**BURNING

Rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe)

Is your pain: Sharp Dull Stabbing Aching Burning Throbbing

Does your pain radiate? Where? ____________________________

Do you feel pain: Occasionally (up to 25% of the day)

Intermittent (up to 50% of the day)

Frequent (up to 75% of the day)

Constant (up to 100% of the day)

Does your pain interfere with your activities of daily living: ______

If so, explain (house cleaning, sleep, work, etc):_______________

____

What makes your pain worse:_______________________________

____

What alleviates your pain (ice, heat, meds, etc):_______________

____

Have you seen any other doctors for this condition:_____________

____

Did you have any testing done for this condition (XRAY, MRI,etc):

____

TO HELP US BETTER UNDERSTAND YOUR CURRENT STATE OF HEALTH, PLEASE COMPLETE THE FOLLOWING PAGE, EVEN IF YOU THINK IT DOES NOT APPLY TO WHAT YOU ARE BEING SEEN FOR TODAY.

Previous Accidents with Dates: ____

____

Surgeries (with Dates): ____

____

Hospitalizations (with Dates):____

____

Allergies: ____

List ALL medications or vitamins currently taking:____

____

DO YOU HAVE ANY CONDITIONS RELATED TO:

[ ] Heart	[ ] Diabetes	[ ] Cancer	[ ] Stroke
[ ] High Blood Pressure	[ ] Thyroid	[ ] Tuberculosis	[ ] Enlarged Prostate
[ ] Kidney	[ ] Asthma	[ ] Ulcer	[ ] Seizure

Other Disorders:____

Do you smoke: Y N How Much? _________________________

For Women: Are you taking Birth Control? Y N

Are you pregnant? Y N Are you presently nursing? Y N

Agreement:

I understand it is my responsibility to cover ALL costs billed and such payment is not contingent on payment by my insurance company, settlement, judgement, or verdict by which I might eventually recover. I understand that the office has the right to bill me for a visit if I do not provide 24 hours notice of cancellation. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature: ____ Date: ____________________________