WELCOME TO MOUNTAINTOP CHIROPRACTIC

PERSONAL INFORMATION

Name:______________________________
Address:______________________________
____
Birthdate:______________________________
Marital Status:__________________________
Home Phone:____________________________
Cell Phone:_____________________________
Work Phone:____________________________
E-mail:________________________________
Employer:______________________________
Emergency Contact:_______________________
Family Physician:_________________________
Who may we thank for referring you?____________________________________

INSURANCE INFORMATION

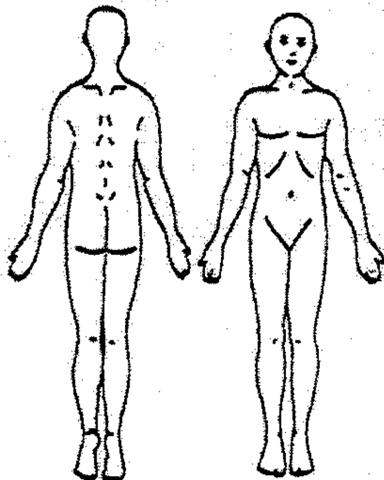
Insurance Co Name:___________________
Address:_____________________________
Phone #:_____________________________
Insured's Name:________________________
Insured's DOB:_________________________
Group #:_____________________________
Insured's Employer:____________________

REASON FOR VISIT

If you are here for **wellness** services and have no current complaints or symptoms, please check here_____ and skip to the **back** of this form. Otherwise, please complete the following questions:

Primary reason for today's visit:____
Is your condition caused by: ___Auto Accident ___Work Accident ___Sports Injury ___Injury ___Other
Date condition/injury began: ____
Describe how your condition/injury began:____
____

PLEASE MARK LOCATIONS 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 day)
Intermittent (up to 50% of day)
Frequent (up to 75% of day)
Constant (100% of day)
Does the 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):_______________
____

TO HELP US BETTER UNDERSTAND YOUR CURRENT STATE OF HEALTH, PLEASE LIST ANY OF THE FOLLOWING, EVEN IF YOU DON'T THINK IT APPLIES TO WHAT YOU ARE BEING SEEN FOR TODAY:

Previous Accidents with Dates:____

____

Surgeries (with Dates) and any hospitalizations you've had:____

____

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 Disorder:____

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 a cancellation. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also aurthorize 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:____________________

REVIEW OF SYSTEMS (PLEASE CHECK ANY SYMPTOMS THAT YOU ARE FEELING, EVEN IF YOU THINK IT DOES NOT APPLY TO YOUR VISIT TODAY):

Allergic-Immunologic [ ] Negative

[ ] Hives/Eczema [ ] Hay Fever [ ] Catches colds easily [ ] Freq Sinus Trouble [ ] Frequent Influenza [ ] HIV

[ ] AIDS [ ] Allergies [ ] Fever

Cardiovascular [ ] Negative

[ ] Murmur [ ] Chest Pain [ ] Palpitations [ ] Dizziness [ ] Fainting Spells [ ] Shortness of Breath

[ ] Difficulty Laying Flat [ ] Swollen Ankles [ ] Heart Attack [ ] Irregular Heartbeat [ ] Pressure over the Chest

[ ] Pain down the Left Arm [ ] High Blood Pressure [ ] Low Blood Pressure [ ] High Triglyceride [ ] High Cholesterol

[ ] Perfuse Sweating [ ] Nausea [ ] Vomiting

Constitutional [ ] Negative

[ ] Weight Loss [ ] Fatigue [ ] Fever

Ear, Nose, Throat [ ] Negative

[ ] Difficulty Hearing [ ] Buzzing in Ears [ ] Ringing in Ears [ ] Vertigo [ ] Sinus Trouble [ ] Nasal Stuffiness

[ ] Freq Sore Throat [ ] Hearing Loss [ ] Ear Pain [ ] Mouth Sores [ ] Horsens [ ] Nose Bleeds [ ] Dental Problems

[ ] Difficulty Swallowing

Endocrine [ ] Negative

[ ] Loss of Hair [ ] Heat/Cold Intolerance [ ] Hypothyroidism [ ] Hyperthyroidism [ ] Diabetes [ ] Goiter

Eyes [ ] Negative

[ ] Glasses/Contacts [ ] Eye Pain [ ] Lights Bothers [ ] Double Vision [ ] Cataracts [ ] Vision Problems

[ ] Blurred Vision [ ] Glaucoma

Gastro-Intestinal [ ] Negative

[ ] Heartburn/ Reflux [ ] Nausea/Vomiting [ ] Constipation [ ] Changes in Bowel Movements [ ] Diarrhea

[ ] Jaundice [ ] Abdominal Pain [ ] Black or Bloody Stools [ ] Gallbladder Problems [ ] Liver Problems

[ ] Hepatitis [ ] Distress from Greasy Food [ ] Pain over Stomach [ ] Burning in Stomach [ ] Ulcers

[ ] Hiatal Hernia [ ] Colitis [ ] Blood in Stool [ ] Mucus in Stool [ ] Pancreatitis [ ] Colon Cancer

Genitourinary [ ] Negative

[ ] Burning/ Frequency [ ] Blood in Urine [ ] Erectile Dysfunction [ ] Abnormal Discharge [ ] Leakage

[ ] Incontinence [ ] Kidney Infection [ ] Sexual Difficulty [ ] Kidney Stones [ ] Loss of Libido

Hematologic/Lymph [ ] Negative

[ ] Easy Bruising [ ] Gums Bleed Easily [ ] Enlarged Glands [ ] Anemia [ ] Bleeding Disorder

[ ] Sickle Cell Anemia [ ] Lymphoma

Musculoskeletal [ ] Negative

[ ] Joint Pain/ Swelling [ ] Stiffness [ ] Muscle Pain [ ] Neck Pain [ ] Stiff Neck [ ] Back Pain [ ] Arthritis

[ ] Osteoarthritis [ ] Rheumatoid Arthritis [ ] Bone Spurs [ ] Broken Bones [ ] Compression Fractures

[ ] Head Injury [ ] Neck Injury [ ] Back Injury [ ] Spinal Trauma [ ] Birth Trauma [ ] Birth Defects

[ ] Cancer [ ] Muscle Weakness [ ] Osteoporosis [ ] Muscular Dystrophy [ ] Sheuermann's Disease

[ ] Scoliosis [ ] Lupus [ ] Spina Bifida [ ] Spondylolisthesis

Neurological [ ] Negative

[ ] Loss of Strength [ ] Numbness [ ] Headaches [ ] Heavy Head [ ] Tremors [ ] Memory Loss

[ ] Lightheaded/ Dizzy [ ] Difficulty Speaking [ ] Multiple Sclerosis [ ] Parkinson's Disease [ ] Fainting

[ ] Concussion [ ] Migraines [ ] Epilepsy/ Seizure [ ] Disorientation [ ] Loss of Coordination

[ ] Difficulty in Walking [ ] Stroke [ ] Alzheimer's Disease [ ] Weakness [ ] Tingling [ ] Disc Problem

Psychiatric [ ] Negative

[ ] Anxiety [ ] Depression [ ] Mood Swings [ ] Difficulty Sleeping [ ] Nervousness [ ] Tension

Respiratory [ ] Negative

[ ] Cough [ ] Coughing Blood [ ] Wheezing [ ] Chills [ ] Chronic Cough [ ] Pneumonia [ ] Difficulty Breathing

[ ] Asthma [ ] Superficial Breathing [ ] Chest Pain [ ] Tuberculosis [ ] Bronchitis [ ] Emphysema

[ ] Lung Cancer

Skin [ ] Negative

[ ] Rash/ Sores [ ] Lesions [ ] Itching/ Burning [ ] Skin Problem [ ] Slow Healing [ ] Bruise Easily

[ ] Discolorations [ ] Psoriasis [ ] Change in Moles [ ] Change in Skin Color [ ] Skin Cancer [ ] Scars

Females ONLY [ ] Negative

[ ] Hot Flashes [ ] Vaginal Discharge [ ] Nipple Discharge [ ] Menstrual Cramps [ ] Premenstrual Depression

[ ] Lumps in Breast [ ] Hysterectomy

Males ONLY [ ] Negative

[ ] Burning on Urination [ ] Difficulty in Starting Urine [ ] Dripping Urination [ ] Prostate Problems

[ ] Prostate Cancer

General [ ] Negative

[ ] Recent Weight Gain [ ] Loss of Sleep [ ] Recent Weight Loss [ ] Loss of Appetite [ ] Fatigue [ ] Polio

[ ] Rheumatic Fever [ ] Cancer of Any Kind