Patient Information

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____

E-mail Address _____

Age _____ Date of Birth _____ Occupation _____ Sex (M) (F)

Referred by _____

Emergency Contact _____

Have you ever had chiropractic care before? _____

For what problem? _____

Were the results satisfactory? Yes_____ No_____

Major complaints and symptoms — please be as specific as you can._____

_____

How do you believe your problem (pain) began? _____

_____

_____

When did you first notice this problem/pain? _____

Have you lost any work? _____ Day and date you last worked _____

Have you ever had this condition before or a similar condition? _____

When? _____

Have you ever been treated by a Medical Physician for this ailment?_____

Where?

_____

Health History Form

PATIENT NAME: _____ FILE #. _____
DATE OF BIRTH: _____
DATE: _____

Do you have vertigo (dizziness)?	Yes _____	No _____
Do you pass out easily (faint or loss of consciousness)?	Yes _____	No _____
Do you have double vision or have you lost sight in one eye?	Yes _____	No _____
Do you have any slurred speech or difficulty with speech?	Yes _____	No _____
Do you have indigestion or difficulty swallowing?	Yes _____	No _____
Do you have any difficulty walking, with coordination or falling to one side?	Yes _____	No _____
Do you have nausea or vomiting?	Yes _____	No _____
Do you have numbness on one side of your face or body?	Yes _____	No _____
Do you have any visual disturbances or rapid eye movement?	Yes _____	No _____
Do you have or have you ever had difficulty in arranging words properly?	Yes _____	No _____
Do you have a headache or head pain that is unlike any you have had before?	Yes _____	No _____
Do you have headaches for hours or days?	Yes _____	No _____
Do you have a history of stroke in your family?	Yes _____	No _____
Do you have chest pain?	Yes _____	No _____
Do you have any change in bowel or bladder habits?	Yes _____	No _____
Do you have a sore that does not heal?	Yes _____	No _____
Do you have any unusual bleeding or discharge?	Yes _____	No _____
Do you have any thickening in your breasts or elsewhere?	Yes _____	No _____
Do you have a change in any wart or mole?	Yes _____	No _____
Do you have a nagging cough or hoarseness?	Yes _____	No _____
Do you have night sweats?	Yes _____	No _____
Do you have pain in neck, jaw or face?	Yes _____	No _____
Do you have a drooping eyelid or change in your pupils?	Yes _____	No _____
Do you have any ringing in your ears?	Yes _____	No _____
Do you take birth control pills?	Yes _____	No _____

What prescription medication are you taking if any?

- [ ] High blood pressure medication
- [ ] Blood thinners
- [ ] Herb, vitamins, or over the counter products
- [ ] Other _____

_____

Health History Form

Have you ever had cancer? Yes ____ No ____
Does you pain ever wake you from a sound sleep? Yes ____ No ____
Are you losing weight now without trying? Yes ____ No ____
Are you coughing up blood or noticing it in your stools or urine? Yes ____ No ____
Have you had any loss of bladder or bowel control? Yes ____ No ____
Have you lost consciousness or had double vision recently? Yes ____ No ____
Are you seeing any other doctor now for any reason? Yes ____ No ____
Note: _____
Are you taking any medication or over-the-counter drugs? Yes ____ No ____
Please indicate type (aspirin, etc.) _____
Are you taking herbs, nutriceuticals, botanicals, or vitamins?
Please list _____
What was the date of onset of your last menses? _____
Are you pregnant? Yes_____No_____

Social History

SMOKER _____ Yes or _____ No, If Yes, how many packs _____
ALCOHOL _____ Yes or _____ No, If Yes, how much _____

Family History

Did you mother or father have any of the following:
Put an **M** for mother, **F** for father, and **B** for both.

( ) High Blood Pressure
( ) Heart Attack
( ) Emphysema
( ) Seizure-Convulsions
( ) HIV Positive
( ) Asthma
( ) Diabetes
( ) Kidney Disease
( ) Ulcer or Stomach Problems
( ) Stroke (Please indicate age when stroke occurred, Mother _____ Father _____)
( ) Arthritis-Rheumatism
( ) Mental Illness
( ) Thyroid Disease
( ) Circulation Problems
( ) Cancer

Comments: _____
_____
_____
_____
_____
_____

Health History Form

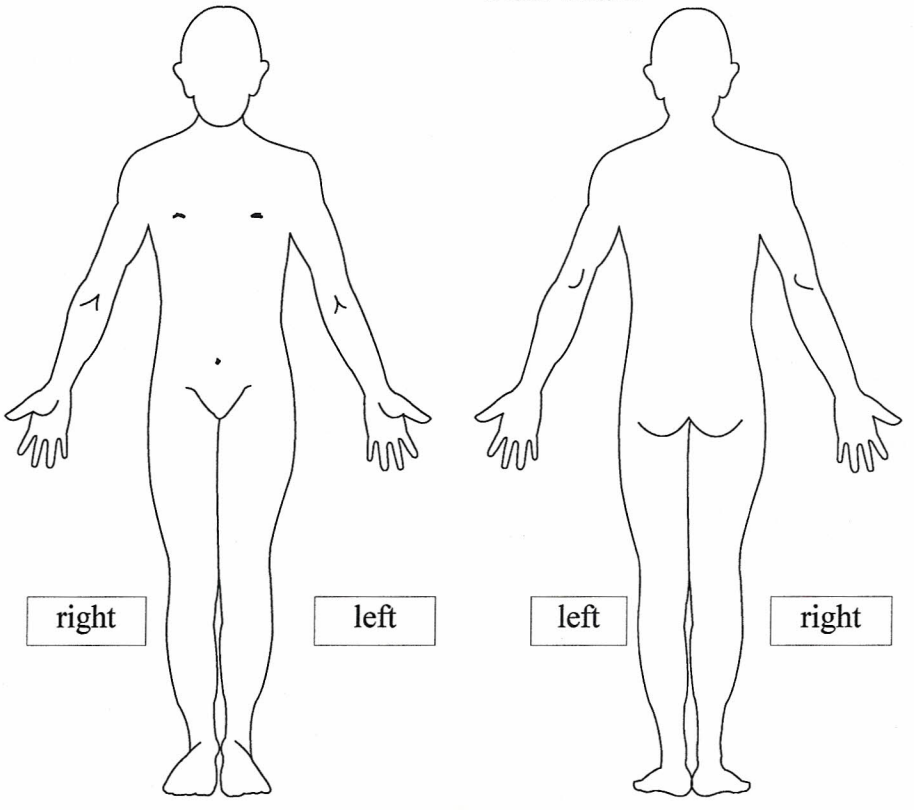
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/ / / / /
- - - - -	00000	xxxxx	*****	/ / / / /
- - - - -	00000	xxxxx	*****	/ / / / /

Please mark on the pain scale from 0 to 10 the pain you feel with this condition.
10 being the worst pain you have felt with this condition.

Pain Chart



Neck-Shoulder-Arm-Pain
On a scale of zero to 10, I rate r
discomfort as follows:
(_____)
0 **10**
no pain **severe pain**

Mid Back Pain
On a scale of zero to 10, I rate r
discomfort as follows:
(_____)
0 **10**
no pain **severe pain**

Low Back and Leg Pain
On a scale of zero to 10, I rate r
discomfort as follows:
(_____)
0 **10**
no pain **severe pain**

Date: _____ Signature _____

SIZEMORE CHIROPRACTIC AND REHABILITATION, LLC

AUTHORIZATION FOR TREATMENT

I hereby authorize such examinations, x-rays (if indicated by exam), treatments and physical rehabilitation as may be prescribed by Dr. Leslie Sizemore of **Sizemore Chiropractic and Rehabilitation, LLC.** in charge of my care.

ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I understand that I am responsible for all medical expenses regardless of insurance coverage and whether or not there is an accident with another person at fault. I understand that I am responsible for any deductibles, co-pays, co-insurance or amounts for services not covered by my insurance carrier.

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Dr. Leslie Sizemore of Sizemore Chiropractic and Rehabilitation, LLC. for any chiropractic benefits by any and all insurance agencies.

ACKNOWLEDGMENT OF PROVISION OF NOTICE OF PRIVACY PRACTICE

I understand that Sizemore Chiropractic and Rehabilitation, LLC. will use and disclose my personal health information according to the Privacy Act.

_____ _____

(Signature of Patient, Parent or Guardian) (Date)

DESIGNATION OF PERSONAL REPRESENTATIVE

I hereby designate the following individual(s) as my personal representative(s) and authorize the release or any verbal or written information as needed to assist in my ongoing treatment, as prescribed by Sizemore Chiropractic and Rehabilitation, LLC. This designation and authorization will remain in effect until revoked in writing.

PERSONAL REPRESENTATIVE NAME **DATE**

_____ _____

_____ _____

_____ _____