CONFIDENTIAL HEALTH INFORMATION

Name:_____ Date:_____ Pat. # _____
Address:_____City:_____ State:_____ Zip:_____
Email _____ Cell Phone _____
Home Phone:_____ Date of Birth:_____ Social Security # _____
Occupation: _____ Employer's Name:_____ Work Phone:_____
Marital Status (circle): Married Single Spouse's Name_____ Spouse Ph.# _____
Your Age _____ Gender (circle): Male Female # Children _____ Spouse's Occupation _____
How did you hear about us — or whom may we thank for referring you?_____
Have you seen a chiropractor before — if so, When? _____ If so, Who?_____
What was your experience _____ Preferred Contact Method: ○ Home ○ Cell ○ Work ○ Email

Primary Complaint/Present Health Condition

PRIMARY SYMPTOM that prompted me to seek care today is: _____
_____
And are the result of (circle): An accident or injury @ Work / Auto / Other_____
Onset (When did you first notice your current symptom?) _____
Prior care: (What have you done to relieve the symptom?) ○ Prescription/Over the counter Meds ○ Physical Therapy
○ Chiropractic ○ Massage ○ Acupuncture ○ Ice/ Heat ○ Surgery ○ Other _____
Intensity of pain (circle number**)** 1—2—3—4—5—6—7—8—9—10 **Duration :** ○ Constant ○ Frequent ○ Occasional
Type of Pain (Circle ALL that apply): Numbness Aching Burning Tingling Radiates Shooting Stiffness Dull Sharp
What actions can you take that temporarily decrease the pain?_____
What activities/movements increase/worsen your condition?_____
Symptom getting: ○ **worse** ○ **same** ○ **better**
Is it worse in the morning or evening? _____ **What position do you normally sleep in?** _____
On a scale of 1 – 10, how committed are you to getting rid of your pain/complaint? (With 10 being most committed) _____
On a Scale of 0 – 10 (10 being unbearable, 0 being No Pain) Please rate the following:
The HIGHEST your pain/symptom gets WITHOUT medication _____ The LOWEST your pain/symptom gets WITH medication _____

Supplemental Health History

Have you had similar health problem or injury before: Yes No If yes explain: _____
_____
Have you lost time from work? **YES / NO** How much time and what have you been unable to perform? _____
Have you lost time from your obligations at home? **YES / NO** How much time and what tasks have been limited? _____
_____
Have you lost any time from enjoying your Leisure activities (Hobbies, Travel, Sports, etc.)? **YES / NO** How much time and which activities? _____
List the approximate dates of any accidents, operations, illnesses, or serious injuries (including broken bones) you have had: _____
Any previous back/neck surgery: How many _____ Approx. Date(s) _____
Back/Neck injections: How many _____ Approx. Date(s) _____
Have you been diagnosed with (circle) : Disc Herniation Disc Degeneration Disc Bulge Stenosis Other _____
Have you had (circle & area) : MRI _____ CT Scan _____ NCV's _____
Date & Location of : _____ _____ _____

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Activities of Daily Living — **How does this condition currently interfere with your life and ability to function?**	**No Effect**	**Mild Effect**	**Moderate Effect**	**Severe Effect**
Sitting				
Rising out of chair				
Standing				
Walking				
Lying down				
Bending over				
Climbing stairs				
Using a computer				
Getting in/out of car				
Driving a car				
Looking over shoulder				
Caring for family				
Grocery shopping				
Household chores				
Lifting objects				
Reaching overhead				
Showering or bathing				
Dressing myself				
Love life				
Getting to sleep				
Staying asleep				
Concentrating				
Exercising				
Yard Work				
Career/Job				

Please check the prescription OR over the counter drugs you are currently taking:

□ Anti-Inflammatory □ Muscle Relaxers □ Pain Pills □ Aspirin □ Tylenol □ Motrin □ Advil
□ Birth Control Pills □ Blood Pressure □ Diet Pills □ Blood Sugar Medication □ Insulin
□ Sleeping Pills □ Anti-depressants □ Other _____

***Have you recently had or do you have a scheduled appointment with an orthopedic surgeon or neurosurgeon for neck or back surgery/consultation? ☐ YES ☐ NO If YES explain _____

_____

Acknowledgements: To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initial Ea.

_____ I instruct Dr. Roffler and or Dr. Pancake to deliver the care that, in his professional judgment, can best help me in the restoration of my health. Chiropractic is designed to reduce or correct vertebral subluxations. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY)_____

_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

_____ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care).

_____ _____ _____

Patient (or Guardian) Signature Date (MM/DD/YYYY) Doctor Initial

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