DeLong - Ryan Chiropractic

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Confidential Patient Data

♥ IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST!♥

PATIENT INFORMATION **Today's Date:**_____

Name:_____ Date Of Birth:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Work Phone:_____

Email Address: _____

Social Security Number:_____ Age:_____ □ Male □ Female

Name of Spouse or Nearest Relative:_____ Phone:_____

Your Occupation:_____ Employer:_____

Referred to this Office by: □ Friend/Family member – Name?_____

□ Yellow Pages □ Mailing □ Location (drove by) □ Other_____

Payment For Services Will Be By: □ Cash/Check □ Mastercard/Visa/AMEX

□ Health Insurance □ Auto Insurance/PIP Claim □ Worker's Compensation

MEDICAL/FAMILY HISTORY **S=Self** **M=Mother** **F=Father**

(Please indicate which PAST conditions have been experienced prior to present complaint by marking the appropriate boxes)

S	M	F		S	M	F	
□	□	□	Anemia	□	□	□	Heart trouble
□	□	□	Asthma	□	□	□	High blood pressure
□	□	□	Back pain	□	□	□	Indigestion
□	□	□	Bladder control	□	□	□	Menstrual cramps
□	□	□	Bone fracture	□	□	□	Multiple sclerosis
□	□	□	Cancer	□	□	□	Neck pain
□	□	□	Chest pain	□	□	□	Nervousness
□	□	□	Concussion	□	□	□	Numbness
□	□	□	Diabetes	□	□	□	Polio
□	□	□	Dislocated joints	□	□	□	Poor circulation
□	□	□	Epilepsy	□	□	□	Rheumatic fever
□	□	□	Headaches	□	□	□	Sinus trouble

Have you been treated by a physician for any health condition in the past year? □ Yes □ No

Describe Condition:_____ Date of last physical exam:_____

Do you have a Primary Care Physician? □ Yes □ No Name & location:_____

Surgical History:

1. _____ Year:_____
2. _____ Year:_____
3. _____ Year:_____

Accident History: □ Job □ Auto □ Other 1._____Mo/Yr_____

Including falls □ Job □ Auto □ Other 2._____Mo/Yr_____

□ Job □ Auto □ Other 3._____Mo/Yr_____

Are you pregnant? □ No □ Yes Date of last Menstrual Period:_____

Are you allergic to any medications? □ No □ Yes-_____

Are you taking any medications? □ No □ Yes-_____

_____

□ Too many to list

PLEASE DESCRIBE YOUR CURRENT MAJOR COMPLAINTS:

Pain level on scale of 1 to 10
(1= hardly any pain, 10= maximum pain)

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

When and how did this (these) complaints start? _____
Date Occurred:_____
Symptoms Developed From: □ Job Related Injury □ Auto Accident □ Accident □ Illness □ Fall
□ Unknown Cause □ Gradual Onset
If you were to guess, what do you think is causing your complaints?_____
_____
Symptoms Have Persisted For: #____Hours ____Days ____Weeks ____Months ____Years
Have you ever had this before? □ Yes □ No When?_____
Name & location of Doctors or Therapists previously seen for this condition:_____
_____
Please Check All Activities That **Aggravate** Your Condition: □ Bending □ Lifting
□ Reaching □ Sneezing □ Walking □ Coughing □ Sitting □ Standing
□ Turning Head □ Lying Down □ Straining at Stool
Please Check All Activities That **Relieve** Your Condition: □ Bending □ Lifting
□ Reaching □ Walking □ Sitting □ Standing □ Lying Down □ Turning head
Symptoms are worse in: □ Morning □ Afternoon □ Night
Symptoms/Complaints: □ Come & Go □ Are Constant
Are your complaints waking you up at night? _____ Yes _____ No
Any recent illness that included a high temperature (fever)? _____ Yes _____ No
Any difficulty or pain when using the restroom for bowel or bladder functions? _____ Yes _____ No

Please Check Any Additional Symptoms You May Be Experiencing:

□ blurred vision □ buzzing in ears □ cold hands/feet □ cold sweats □ constipation
□ concentration loss □ depression □ diarrhea □ dizziness □ flushed face
□ fainting □ fatigue □ head seems heavy □ fever □ headaches
□ insomnia □ light sensitivity □ loss of balance □ loss of smell □ loss of taste
□ low immunity □ muscle jerking □ numbness in fingers □ numbness in toes
□ pins & needles–legs □ pins & needles-arms □ ringing in ears □ shortness of breath
□ stiff neck □ stomach upset

OFFICE POLICY:

♥ Professional care is given to you, our patient, not to an insurance company. Thus, the insurance company is responsible to the patient and the patient to the doctor. As a courtesy to you, we will bill your insurance and help in any way we can to get your claims taken care of. Health insurance plans often cover portions of chiropractic. Please be sure to examine your insurance plan carefully. We will not allow an account to reach an amount over $200.00 without some form of payment.

♥ Appointments that cannot be kept must be rescheduled or cancelled 24 hours in advance to avoid a missed appointment charge.

Signature (patient or guardian)_____Date_____

PATIENT NAME:_____ DATE_____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D= Dull	S= Stabbing
B= Burning	T= Tingling (pins & needles)
N= Numb	C= Cramping