ROCKPOINT CHIROPRACTIC
AN UPPER CERVICAL CENTER

# Confidential Health Information

Please allow our staff to photocopy your insurance card.
All information you supply is confidential.
We comply with all federal privacy standards.
Please print clearly.

Today's Date:_____

Referred by:_____

Patient's Name:_____

Address:_____

City:_____State:_____Zip:_____

Home phone:_____Cell:_____

Email:_____

Gender: ☐ Female ☐ Male Date of Birth:_____Age:_____

S.S. #_____

Emergency Contact & Relationship:_____

Phone:_____

Employer:_____

Occupation:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____

Do you have health insurance? ☐Yes ☐No
Name of Company:_____

**If today's visit is the result of an auto accident or work injury, insurance information or claim number must be provided**

Marital Status
☐S ☐M ☐D ☐W

Spouse's Name:_____

Are you pregnant? ☐Yes ☐No
Number of weeks:_____

Have you been to a chiropractor before:_____

_____

Surgeries & dates:_____

_____

_____

_____

Children's names & ages :_____

_____

_____

Your Hobbies/interests:_____

_____

_____

_____

1. What symptoms prompted you to seek chiropractic care:_____

_____

2. Is it the result of an: ☐ Auto Accident ☐ Work Accident ☐ Other Date of accident:_____

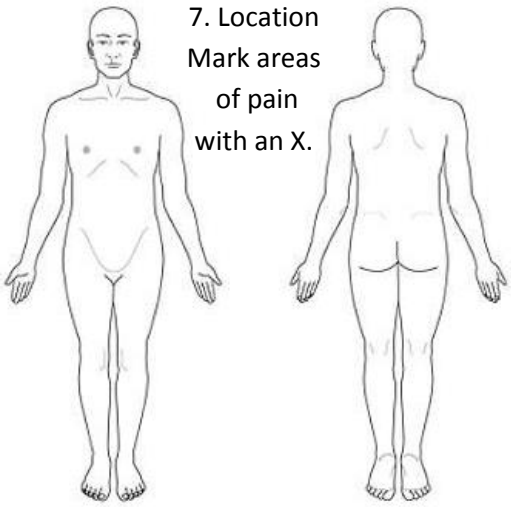
3. When did your symptoms start:_____ 4. How intense is the pain? 1-2-3-4-5-6-7-8-9-10

5. How often do you feel the pain? ☐ Constant ☐ Comes and goes

6. Type of Pain:

- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Cramping
- ☐ Sharp
- ☐ Burning
- ☐ Shooting
- ☐ Throbbing
- ☐ Stabbing
- ☐ Other____

7. Location Mark areas of pain with an X.



8.Does the pain radiate, shoot, or travel?

- ☐ Yes, where:_____
- ☐ No

9. What makes the pain worse:_____

_____

What makes the pain better:_____

_____

10. Symptom relief you've tried:

- ☐ Rx pain killers or muscle relaxers
- ☐ OTC pain killers (Ibuprofen, Tylenol etc)
- ☐ Physical therapy ☐ Acupuncture
- ☐ Chiropractic ☐ Massage Therapy
- ☐ Surgery ☐ Ice/Heat
- ☐ Other_____

11. What else would you like Dr. Fancher to know:_____

_____

_____

12. Does your current condition interfere with or make any of these activities more difficult or painful?

☐ Sitting ☐ Standing ☐ Lying Down ☐ Lifting ☐ Bending over

☐ Work ☐ Recreation ☐ Other:_____

13. Review of body systems

Chiropractic care focuses on the integrity of the nervous system, which controls and regulates your entire body. Please mark which conditions you have had or are currently having issues with.

| Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Osteoporosis | ☐ | ☐ | Headache | ☐ | ☐ | Psoriasis |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Depression | ☐ | ☐ | Eczema |
| ☐ | ☐ | Poor Posture | ☐ | ☐ | Anxiety | ☐ | ☐ | Acne |
| ☐ | ☐ | Scoliosis | ☐ | ☐ | Dizziness | ☐ | ☐ | Hair loss |
| ☐ | ☐ | TMJ | ☐ | ☐ | Numbness | ☐ | ☐ | Blurred vision |
| ☐ | ☐ | Foot/Ankle pain | ☐ | ☐ | Pins & needles | ☐ | ☐ | Ringing in ears |
| ☐ | ☐ | Neck pain | ☐ | ☐ | High blood pressure | ☐ | ☐ | Hearing loss |
| ☐ | ☐ | Shoulder pain | ☐ | ☐ | Low blood pressure | ☐ | ☐ | Chronic ear infection |
| ☐ | ☐ | Back pain | ☐ | ☐ | High cholesterol | ☐ | ☐ | Asthma |
| ☐ | ☐ | Knee pain | ☐ | ☐ | Poor circulation | ☐ | ☐ | Allergies |
| ☐ | ☐ | Hip pain | ☐ | ☐ | Easy bruising | ☐ | ☐ | Pneumonia |

13. Review of body systems continued…

| Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Immune disorders | ☐ | ☐ | Shortness of breath | ☐ | ☐ | Diarrhea |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Sleep apnea | ☐ | ☐ | Food allergies |
| ☐ | ☐ | Fibromyalgia | ☐ | ☐ | Emphysema | ☐ | ☐ | Thyroid issues |
| ☐ | ☐ | Kidney stones | ☐ | ☐ | Ulcers | ☐ | ☐ | Hypoglycemia |
| ☐ | ☐ | Bed wetting | ☐ | ☐ | Heartburn | ☐ | ☐ | Low energy/fatigue |
| ☐ | ☐ | Prostate issues | ☐ | ☐ | Constipation | ☐ | ☐ | Erectile dysfunction |
| ☐ | ☐ | Sudden weight change | ☐ | ☐ | PMS | ☐ | ☐ | Other:_____ |
| ☐ | ☐ | Poor appetite | ☐ | ☐ | Infertility | | | |

_____

14. Medications you take (prescription and/or over the counter):_____

_____

15.Nutritional supplements, vitamins, herbs, etc. :_____

_____

16. Do you have any other health goals?_____

_____

17. What are you looking for most in a chiropractor? _____

_____

**Acknowledgements** – to set clear expectations, improve communications, and help you get the best results, please read each statement and initial your agreement.

**Initials_____** I instruct the chiropractor to deliver the care that, in his professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

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

**Initials_____** I realize that an x-ray may be hazardous to an unborn child and I certify that to the best of my knowledge that I am not pregnant.

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

**Initials_____**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.

**Initials_____**To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

_____

Print patient's name

_____ _____

Signature of patient or responsible party Date