Active Care Family Chiropractic

113 S. Main St. Summerville, SC 29483
Phone: (843) 871-2472 Fax: (843) 871- 0400

Confidential Patient Information

Patient Name: ______________________________

Email Address: ______________________________

Address: ____________________ City: __________ State: ________ Zip:

Home Phone: ______________ Cell: ______________ Work: ______________

Social Security#: ______________ DOB: ____/____/____ Age: ______ Sex: M / F Marital Status: __________

Patients Employer: ____________________ Occupation: ______________

Employer Address: ______________ City: __________ State: ________ Zip: __________

Emergency Contact: ______________ Phone #: __________ Relationship to Patient: __________

Referred By: ______________________________

Insurance Information: (Insurance Holder Information)

Insured Name: ______________ Insured DOB ____/____/____ SS#: ______________

Relationship to Patient: ______________ Insured ID #: ______________ Group #: ______________

Insurance Company: ______________ Address: ______________

Treatment of a Minor

I, ______________________, give my permission to Inner Health Chiropractic and its representatives to render the necessary treatment to my child, ______________________.

Parent/Guardian Signature: ______________ Phone #: ______________ Date: __________

Authorization for Assignment of Benefits/Information Release:

I authorize payment of medical insurance benefits to Active Care Family Chiropractic for any services furnished to me. I also authorize you to release medical information concerning my health care to any attorney, insurance company, or third-party payors, and/or their respective agent(s). This information will be used for the purpose of evaluation and administering claim benefits. Also, a 24- hour notice is necessary to cancel my appointment, and you may be responsible for payment for a missed appointment.

Patients Signature: ______________________________ Date: ______________

Purpose of Visit

What is your Main Health Concern? ____

When did this concern begin? ____/____/____

Did it begin: Gradual Sudden Progressive over time

Is this concern related to an auto accident / work injury? Yes No

What activities aggravate your symptoms? ____

Is there anything, which has relieved your symptoms? Yes No

Describe: ____

Is this condition getting worse? Yes No

How often do you experience these symptoms throughout the day?

100% 75% 50% 25% 10% Only with Activity

Does complaint(s) interfere with:

__ Work __ Sleep __ Hobbies __ Daily Routine

Explain: ____

Have you experienced this condition before? Yes No If so, please explain: ___________________________________

Who have you seen for this? __________________________ What did they do? ____________________________

How did you respond? ____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? Yes No Who? __________________________ When? ____________

Reason for visits: ____

How did you respond? ____

Did your previous chiropractor take before and after x-rays? Yes No

Did you know posture determines your health? Yes No Are you aware of any of your poor posture habits? Yes No

Explain: ____

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _______________________________

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming Other: ____________

Do you smoke? Yes No How much? ____

Do you drink alcohol? Yes No How much / week? ____

Do you drink coffee? Yes No How many cups / day? ____

Do you take any supplements (i.e. vitamins, minerals, herbs)? Yes No What? ____

Are you interested in taking supplements (i.e. vitamins, minerals, herbs)? Yes No

HEALTH CONDITIONS AND PAST MEDICAL HISTORY

CERVICAL SPINE (NECK): ______

Postural distortions in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body.

Do you experience…?

__ Neck Pain
__ Pain into your shoulders/arms/hands
__ Numbness/tingling in arms/hands
__ Hearing disturbances
__ Weakness in grip
__ Headaches
__ Dizziness
__ Visual disturbances
__ Coldness in hands
__ Thyroid conditions
__ Sinusitis
__ Allergies/Hay fever
__ Recurrent colds/Flue
__ Low Energy/Fatigue
__ TMJ/Pain/Clicking

Explain: ______

THORACIC SPINE (UPPER BACK): ______

Postural distortions in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body.

Do you experience…?

__ Heart Palpitations
__ Heart Murmurs
__ Tachycardia
__ Heart Attacks/Angina
__ Recurrent Lung Infections/Bronchitis
__ Asthma/Wheezing
__ Shortness Of Breath
__ Pain On Deep Inspiration/Expiration

Explain: ______

THORACIC SPINE (MID BACK): ______

Postural distortions in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body.

Do you experience…?

__ Mid Back Pain
__ Pain Into Your Ribs/Chest
__ Indigestion/Heartburn
__ Reflux
__ Nausea
__ Ulcers/Gastritis
__ Hypoglycemia
__ Tired/Irritable after eating or when you haven’t eaten for a while

Explain: ______

LUMBAR SPINE (LOW BACK): ______

Postural distortions will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body.

Do you experience…?

__ Pain into your hips/legs/feet
__ Numbness/tingling in your legs/feet
__ Coldness in your legs/feet
__ Muscle cramps in your legs/feet
__ Constipation / Diarrhea
__ Weakness/injuries in your hips/knees/ankles
__ Recurrent bladder infections
__ Frequent/difficulty urinating
__ Menstrual irregularities/cramping (females)
__ Sexual dysfunction
__ Low back pain

Explain: ______

Please list any health conditions not mentioned: ______

Please list any medications currently taking and their purpose: ______

Please list all past surgeries: ______

Please list all previous accidents and falls: ______