Patient Information

Lakeshore Chiropractic & Sports Rehabilitation

1 Patient Information

Date _____

Patient Name _____

Address (Street)_____

City_____

State_____ Zip_____

Sex M F Age_____

Birthdate _____

Marital Status Single Married Widowed

Please Circle Separated Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Phone _____

Whom may we thank for referring you

_____

Phone Numbers: Cell_____

Home_____

Work_____

Best time and place to reach you:

_____

Office Use Only

Insurance _____

Coverage _____

Deductible _____

Copay or Coinsurance _____

Number of Visits_____

2 Insurance

Who is responsible

for this account_____

Relationship to Patient_____

Assignment and Release

I, the undersigned, certify that I or (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissons.

Responsible Party Signature_____

Date_____Relationship_____

3 Accident Information (Please Circle)

Is this condition due to an accident YES NO

Date of Accident_____

Type of Accident : AUTO WORK HOME OTHER

To whom have you report this accident

Auto Ins Employer Work Comp Other

Attorney Name If Applicable _____

4 Patient Condition (Please Circle)

Reason for your visit:_____

When did your symptoms appear:_____

Is this condition progressively getting worse? YES NO

Please mark and X on the picture at the right where you are have pain, or an + for numbness or tingling

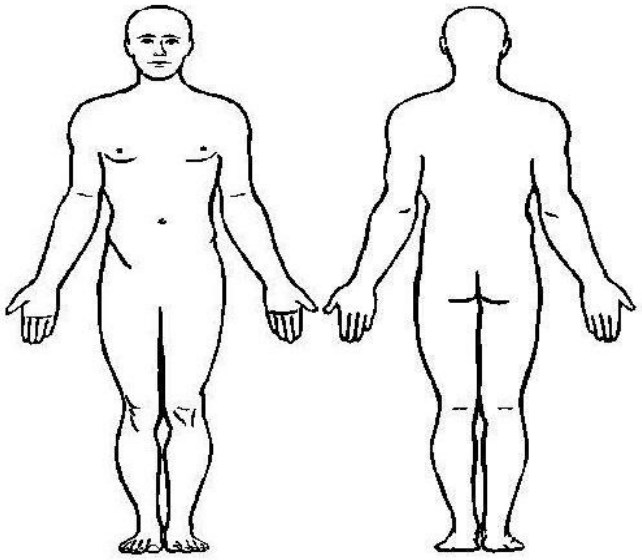
Please rate the severity of pain on a scale of 0 (least) to 10 (severe)_____

Type of Pain: Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling

Is the pain constant or comes and goes_____

Does it interfere with: WORK SLEEP DAILY ROUTINES

Activities or movements that are painful to perform: SITTING STANDING WALKING BENDING LAYING DOWN



Patient Information **Lakeshore Chiropractic & Sports Rehabilitation**

What treatment have you already received for this condition: Medication Surgery Physical Therapy
Chiropractic Services None Other_____
Name and Address of other doctors who have treated you for this condition:_____
Date of last: Phyiscal Exam_____ Spinal Exam_____ Dental x-ray_____
Blood Test_____ Spinal Xray_____ MRI,CT, Bone Scan_____

Exercies	Work Activity	Habits	
None	Sitting	Smoking	Packs/Day_____
Moderate	Standing	Alchol/Drinking	Drinks/Week_____
Daily	Light Labor	Coffee/Caffeine Drinks	Cups/Day_____
Heavy	Heavy Labor	High Stress Level	Reason_____

Injuries/Surgeries You Have Had	Date
Falls:	
Head Injuries	
Broken Bones	
Dislocations	
Surgeries	

Medication	Allergies	Vitamins/Herbs/Minerals
Pharm Name_____		
Pharm Phone_____		

NECK, BACK, EXTREMITIES Circle any of the symptoms you currently have or have had in the past 1 year

Neck	Arms and Hands	Right / Left		Low Back
Pain in Neck	Pain in upper arm	R	L	Low back pain
Neck Stiffness	Pain in elbow	R	L	Low back stiffness
Neck Weakness	Pain in the forarm	R	L	Low back weakness
Pinched Nerve in Neck	Pain in the fingers	R	L	Pinched nerve in low back
Muscle Spasms in Neck	Pins and Needles in arm	R	L	Low back feels out of place
Grinding/Popping in Neck	Pins and Needles in fingers	R	L	Muscle spasm in low back
Shoulders	Numbness in arm	R	L	**Other Symptoms**
Pain in Shoulder Joint R / L	Numbness in fingers	R	L	
Pain across shoulders	Weakness in arm	R	L	
Can't raise arm R / L	Weakness in fingers	R	L	
Above shoulder level	Hands cold	R	L	
Over head	**Hips, Legs, and Feet**	**Right / Left**		
Tension in shoulders	Pain in Buttocks	R	L	
Pinched Nerve in Shoulder	Pain in the hip joint	R	L	
Mid - Back	Pain down the leg	R	L	
Mid back pain	Pain in the ankle	R	L	
Mid back stiffness	Pain in the foot	R	L	
Pain between the shoulders	Weakness of the leg	R	L	
Pain from front to back	Weakness of the knee	R	L	
Muscle spasm in mid back	Leg cramps	R	L	

Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 years?	☐	☐	_____
... had any mental disorders?	☐	☐	_____
... had any broken bones?	☐	☐	_____
... had any strains or sprains?	☐	☐	_____
... ever used orthotics?	☐	☐	_____
Do you take minerals, herbs or vitamins?	☐	☐	_____

How is most of your day spent? ☐ standing, ☐ sitting, ☐ other: _____

How old is your mattress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐
Salty foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐

Check ☑ and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful deification
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow

☐ Reg. ☐ Irreg. ☐ Pain / cramps

Days of flow: ____ Length of cycle: ____

Date - 1st day last period: _____

Are you pregnant? ☐ yes, ☐ no

If yes, how many months? ____

How many children do you have? ____

Birth control method: _____

Date of last PAP test: _____

☐ normal, ☐ abnormal

Date of last mammogram: _____

☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Family History

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

○ Alcoholism	○ Cancer	○ High blood pressure
○ Anemia	○ Diabetes	○ High Cholesterol
○ Arteriosclerosis	○ Emphysema	○ Multiple sclerosis
○ Arthritis	○ Epilepsy	○ Osteoporosis
○ Asthma	○ Glaucoma	○ Stroke
○ Bleed easily	○ Heart disease	○ Thyroid disease