Application for Patient Care

Patient Information

Patient Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ SS#: _____-_____-_____ DOB: ____/____/____ Age: _____ M / F

Home # _____ Cell # _____

Work # _____ Email: _____

Preferred method of contact for appointment reminders? Call / Text / Email

Occupation: _____ Employer: _____

Primary Care Physician: _____ Phone # _____

- *Do we have permission to contact your doctor regarding your care in our office? Yes / No*

Marital Status: __Single __Married __Divorced __Widowed __Separated

Spouse's Name: _____ # of Children_____ Children's Ages _____

Emergency Contact: _____ Phone # _____

Accidents

Have you been in an auto accident? Yes / No If so, when? _____

Have you had a recent fall/other accident? Yes / No If so, when? _____

Have you received: __ Physical Therapy __ Chiropractic Care __ Pain Management Last Visit: _____

Referrals

How did you hear about our office? _____

Insurance Information **PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)**

Do you have health insurance? Yes/No Name of Carrier: _____

Do you have secondary insurance? Yes/No Name of Carrier: _____

Assignment and Release

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, *Alpha Medical Group LLC*, (DBA Arizona's Family Chiropractic) INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. 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, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payments of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

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 care.)*

Signature: _____ Date: _____

PATIENT NAME: _____DATE: _____

ARIZONA'S FAMILY CHIROPRACTIC

Primary Complaint(s): *Please list in order of most severe (#1) to least severe (#4) Sample complaints: Low back, left knee, right shoulder, neck, etc.*

(1) Complaint: _____
How long have you had this complaint? **# _____ Days / Weeks / Months / Years**
Circle the word(s) that best describes this complaint. **Sharp / Dull / Achy / Throbbing / Numb / Shooting / _____**
Does the pain radiate? YES / NO If Yes please describe: _____
How often do you feel this complaint? **Constant / Daily / Weekly / "Off and On"**
Is it getting better, worse, or staying the same? **Better / Worse / Same**
Does anything make it **Better / Worse**? Please explain: _____
On a scale of 0 – 10, rate your discomfort *(0= no pain, 10= excruciating)* **0 1 2 3 4 5 6 7 8 9 10**
Clinic Notes: _____

(2) Complaint: _____
How long have you had this complaint? **# _____ Days / Weeks / Months / Years**
Circle the word(s) that best describes this complaint. **Sharp / Dull / Achy / Throbbing / Numb / Shooting / _____**
Does the pain radiate? YES / NO If Yes please describe: _____
How often do you feel this complaint? **Constant / Daily / Weekly / "Off and On"**
Is it getting better, worse, or staying the same? **Better / Worse / Same**
Does anything make it **Better / Worse**? Please explain: _____
On a scale of 0 – 10, rate your discomfort *(0= no pain, 10= excruciating)* **0 1 2 3 4 5 6 7 8 9 10**
Clinic Notes: _____

(3) Complaint: _____
How long have you had this complaint? **# _____ Days / Weeks / Months / Years**
Circle the word(s) that best describes this complaint. **Sharp / Dull / Achy / Throbbing / Numb / Shooting / _____**
Does the pain radiate? YES / NO If Yes please describe: _____
How often do you feel this complaint? **Constant / Daily / Weekly / "Off and On"**
Is it getting better, worse, or staying the same? **Better / Worse / Same**
Does anything make it **Better / Worse**? Please explain: _____
On a scale of 0 – 10, rate your discomfort *(0= no pain, 10= excruciating)* **0 1 2 3 4 5 6 7 8 9 10**
Clinic Notes: _____

(4) Complaint: _____
How long have you had this complaint? **# _____ Days / Weeks / Months / Years**
Circle the word(s) that best describes this complaint. **Sharp / Dull / Achy / Throbbing / Numb / Shooting / _____**
Does the pain radiate? YES / NO If Yes please describe: _____
How often do you feel this complaint? **Constant / Daily / Weekly / "Off and On"**
Is it getting better, worse, or staying the same? **Better / Worse / Same**
Does anything make it **Better / Worse**? Please explain: _____
On a scale of 0 – 10, rate your discomfort *(0= no pain, 10= excruciating)* **0 1 2 3 4 5 6 7 8 9 10**
Clinic Notes: _____

PATIENT NAME: _____DATE: _____

ARIZONA'S FAMILY CHIROPRACTIC

Patient Health History

Have you taken any of the following for the listed complaints in the last 6 months?

☐ Tylenol ☐ Ibuprofen/NSAIDs ☐ Aspirin

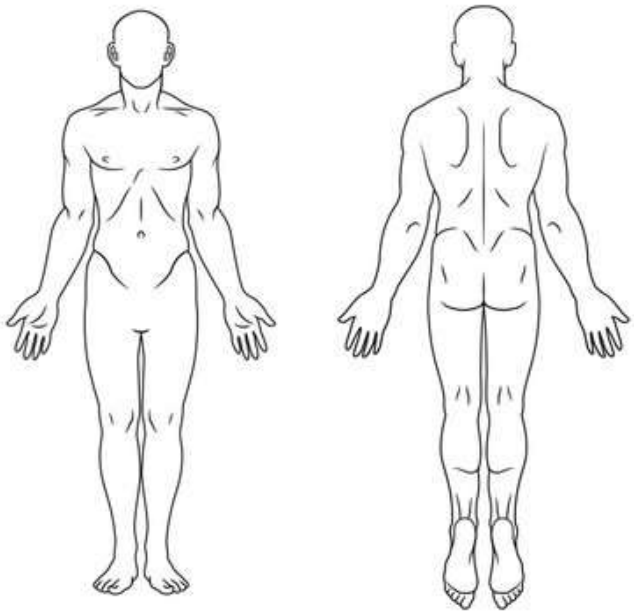
Have you tried any of the following?

☐ Occupational Therapy ☐ Chiropractic ☐ Pain Management ☐ Ice/Heat

How long ago, or how often did you attempt the selected therapies? _____

Please check if you are experiencing any of the following conditions and then circle any areas on the body to the right.

- ☐ Neck Pain/Stiffness
- ☐ Back Pain/Stiffness
- ☐ Arm/Hand Pain
- ☐ Leg/Knee Pain
- ☐ Headaches
- ☐ Loss of Taste
- ☐ Nervousness
- ☐ Jaw Problems
- ☐ Dizziness/Fainting
- ☐ Blurred/Double Vision
- ☐ Mood Changes
- ☐ Pins/Needles in Arms
- ☐ Pins/Needles in Legs
- ☐ Light Bothers Eyes
- ☐ Recent Weight Changes
- ☐ Loss of Memory
- ☐ Cold Extremities
- ☐ Sleeping Difficulties
- ☐ Bowel/Bladder Changes
- ☐ Constipation/Diarrhea
- ☐ Loss of Balance
- ☐ Trouble Concentrating
- ☐ Nausea
- ☐ Night Pain
- ☐ Fatigue
- ☐ Fever
- ☐ Tension
- ☐ Chest Pain
- ☐ Asthma
- ☐ Cold Sweats
- ☐ Loss of Smell
- ☐ Swollen Joints
- ☐ Foot Trouble



Please check if you have ever had any of the following:

- ☐ ADD/ADHD
- ☐ Aids/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma/Wheezing
- ☐ Bad Breath/Taste
- ☐ Bleeding Disorders
- ☐ Blood Pressure: High/Low
- ☐ Breast Lump
- ☐ Broken Bones
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Colon Trouble
- ☐ Contacts/Glasses
- ☐ Depression
- ☐ Diabetes
- ☐ Dry Skin
- ☐ Ear Infections Epilepsy
- ☐ Fibromyalgia
- ☐ Gall Bladder
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heartburn
- ☐ Heart Attack
- ☐ Heart Problems
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Hormone/Gland Problems
- ☐ Insomnia
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Measles
- ☐ Menopausal Problems
- ☐ Migraines
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Mouth Sores/ Bleeding Gums
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Nosebleeds
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Prothesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sexual Difficulty
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ TMJ Pain
- ☐ Tonsillitis
- ☐ Tremors
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whopping Cough
- ☐ Other: _____ _____

Are you currently under drug and/or medical care? YES / NO Explain: _____

PATIENT NAME: _____DATE: _____

ARIZONA'S FAMILY CHIROPRACTIC

Patient Health History continued…

Please list any and all medications, supplements/vitamins, herbs etc. you are currently taking:

Name	Strength/Dosage	Frequency	What are you taking this for?

Please list any surgeries and/or hospitalizations you have had (type and date): _____

_____

Please list any **ALLERGIES** (food/drug/other): _____

_____

X-Ray Questionnaire: For Women Only Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____ Date of last menstrual cycle: _____

- ☐ There is a possibility that I may be pregnant at this time.
- ☐ No, I am definitely not pregnant at this time.
- ☐ Yes, I am definitely pregnant.
- ☐ I request that x-ray films not be taken because:

_____ _____

Patients Signature Date

NEUROLOGICAL/MRI/VASCULAR PATIENT QUESTIONNAIRE

1. Weakness, numbness or burning in your shoulder, arm, or hands?	NO	YES
2. Do your hands or arms fall asleep regularly?	NO	YES
3. Reduced feeling (sensation) or swelling in your hands or arms?	NO	YES
4. Loss of handgrip strength?	NO	YES
5. Weakness, numbness or burning in your buttocks, legs, or feet?	NO	YES
6. Do your legs or feet fall asleep regularly?	NO	YES
7. Reduced feeling (sensation) or swelling in your legs, feet?	NO	YES
8. Cold hands/feet?	NO	YES
9. Have you had an MRI?	NO	YES

If yes to MRI, When? Who ordered it? What was it ordered for?

_____

_____