AccessHealth
CHIROPRACTIC CENTER, PC

1517 OLD APEX ROAD SUITE 118 CARY, NC 27513
(919) 377-0351 WWW.ACCESSHEALTHCHIRO.COM

General Patient Information

Last Name _____ First Name _____ M.I. ____

Address _____ Apt# ____

City _____ State ____ Zip _____

Primary Phone _____ E-mail _____

Date of Birth _____ Age ____ Gender: Male Female

Occupation _____Employer _____

Name of patient's guardian (if applicable) _____

Are you insured by Medicare? Y ☐ N ☐ If so, do you have supplemental insurance as well? Y ☐ N ☐

Besides Medicare/VCP insurance, we are an out-of-network clinic, but we can submit your charges. Would you like us to do that for you? Y ☐ N ☐

How did you hear about us? _____

Have you been to a Chiropractic Physician before? Y ☐ N ☐

If yes, please explain _____

Marital Status:

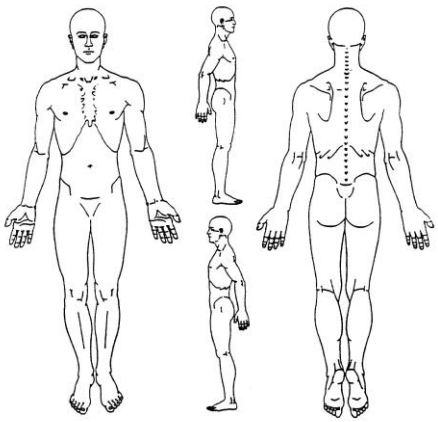
☐ Single ☐ Married ☐ Divorced/Separated ☐Widowed

Height ____ Ft. ____ In. Weight ____ Lbs.

Patient or Parent (Under 18 YOA) Signature: _____ Date: _____

What brings you in to the clinic today?

Mark the area of complaint and/or symptoms in the diagram below:



AccessHealth
CHIROPRACTIC CENTER, PC

1517 OLD APEX ROAD SUITE 118 CARY, NC 27513
(919) 377-0351 WWW.ACCESSHEALTHCHIRO.COM

What is your chief (#1) complaint? _____

Is the complaint related to an auto accident? Yes No

Is the complaint related to a work injury? Yes No

What do you think caused this complaint?

_____

_____

When did the symptoms begin? _____

Have you had previous episodes of this complaint? _____

Describe the quality of your complaint (circle all that apply):

Sharp Pain Dull Pain Ache Weakness Throbbing Numbness Tingling

Shooting Burning Tightness/Stiffness Other: _____

Describe the frequency of your complaint:

Constant (76% or greater) Frequent (51-75%) Occasional (26 – 50%)

Intermittent (25% or less)

Are you experiencing any of the following symptoms?

Pain wake you up at night N Y, Explain: _____

Unexpected weight loss or gain N Y, Explain: _____

Worst headaches of your life N Y, Explain: _____

Vomiting and/or blood in your stool N Y, Explain: _____

Loss of bladder or bowel control N Y, Explain: _____

Indicate the intensity of your pain at its best (b)/worst (w)/average (a) level

No Pain 1 2 3 4 5 6 7 8 9 10 *Most pain*

How are your symptoms changing?

Getting Better Not Changing Getting Worse

Symptoms are worse in the:

Morning Afternoon Night Same all day

How much does the pain interfere with your daily living activities?

None A little bit Moderately Quite a bit Extremely

What daily living activities are difficult because of the complaint?

_____

Does the complaint radiate or travel to any other areas in your body? Yes No

If so, where? _____

AccessHealth
CHIROPRACTIC CENTER, PC

1517 OLD APEX ROAD SUITE 118 CARY, NC 27513
(919) 377-0351 WWW.ACCESSHEALTHCHIRO.COM

Do any of these make your problem better (b) or worse (w)?

Lying down Walking Standing Sitting

Movement/Exercise Inactivity Bending Coughing/Sneezing

Who else have you seen for this complaint? _____

Have you done anything for home treatment? (Ice/heat/NSAID) _____

List any other complaints in order of severity:

1. _____
2. _____
3. _____

Health History

Are you pregnant? N Y **If so how far along are you?** _____

Is this your first pregnancy? Y N **If not how many have you had?** ___

How were your children delivered? ☐ Vaginally____☐ Caesarian____ ☐ V-BAC____

Have you had any complications during delivery? Y N If yes, please explain:

_____

Please list number of Children: ___ Miscarriages: ___ Number of abortions: ___

Name of current pre-natal practitioner (Midwife, OB/GYN): _____

Name of current pre-natal facility: _____

Is your baby (circle if known): Vertex Breech Transverse

Please list any complications you may be experiencing during this pregnancy:

_____

List any medications/vitamins/supplements you are currently taking:

_____

Number of caffeinated drinks/week? _____ **Alcohol drinks/week**? _____

Smoking status: ☐Current smoker ☐Never ☐ Quit ___ years ago

List any confirmed or suspected allergies you have:

_____

In the last 5 years have you had any of the following?

Surgery/Hospitalizations: _____

Serious Illnesses: _____

Traumatic injuries: _____

How many hours of sleep are you currently getting per night? _____ **Is this normal for you?** _____

AccessHealth
CHIROPRACTIC CENTER, PC

1517 OLD APEX ROAD SUITE 118 CARY, NC 27513
(919) 377-0351 WWW.ACCESSHEALTHCHIRO.COM

Do you exercise? Y N

If so, WHAT and HOW OFTEN? _____

Would you consider your current diet to be: Poor Average Clean

Do you have a history or family history of any of the following illnesses/diseases? (Circle S for self, M for mother's side and F for father's side)

Heart Disease	S	M	F	Allergies/Asthma	S	M	F
Hypertension	S	M	F	Cancer	S	M	F
Stroke	S	M	F	Migraines	S	M	F
Arthritis	S	M	F	Back Problems	S	M	F
Diabetes	S	M	F	Lung Disease	S	M	F

Systems Review

<u>Besides the complaint(s) you're here for</u>, do you *currently* or *have you ever* had any of the following? If yes please explain.

Significant *skeletal* complaints such as: fractures, osteoporosis, arthritis, bone pain/bruises, disc herniation, etc.

_____

Significant *muscular* complaints such as: weakness, sprains/strains, lumps, etc.

_____

Significant *neurological* complaints such as: seizures, strokes, numbness/tingling, burning, weakness, poor coordination, headaches, etc.

_____

Significant *skin* complaints such as: rashes, sores, bumps, concerning moles, bruising, itching, hair loss, etc.

_____

Significant *pulmonary* complaints such as: asthma, shortness of breath, wheezing, coughing up blood, difficulty breathing, pneumonia, persistent cough, etc.

_____

Significant *cardiovascular* complaints such as: heart murmurs, heart attacks, heart skipping a beat, chest pain, rapid pulse, high/low blood pressure, varicose veins, foot/ankle swelling, leg cramping, aneurisms, hot/cold feet or hands, etc.

_____

Significant *gastrointestinal* complaints such as: gastric reflux, difficulty eating/drinking, vomiting, bloating, diarrhea, constipation, blood/abnormal stool, hemorrhoids, liver disease, gall bladder disease, etc.

_____

Significant *genitourinary* complaints such as: difficulty urinating, dribbling, bed-wetting, kidney stones, infections, painful intercourse, enlarged prostate, menstrual problems etc.

_____

Significant *psychological* complaints such as: depression, overwhelming anxiety/stress, thoughts of harming yourself/others, mood swings, PTSD, etc.

_____

Significant *eye* complaints such as: poor vision, redness, excessive watering or crustiness, pain behind the eye,

AccessHealth
CHIROPRACTIC CENTER, PC

1517 OLD APEX ROAD SUITE 118 CARY, NC 27513
(919) 377-0351 WWW.ACCESSHEALTHCHIRO.COM

floaters, double vision, light sensitivity, etc.

_____

Significant *ear* complaints such as: loss of hearing, ringing in the ears, feelings of fullness, infection, clear fluid drainage, etc.

_____

Significant *nose* complaints such as: excessive drainage, bleeding, congestion, etc.

_____

Significant *oral* complaints such as: jaw pain, jaw clicking, mouth sores, sore throat, difficulty swallowing, tooth loss, bleeding gums, etc.

_____

Do you have any other health complaints that were not asked about?

_____

Dependency on drugs or alcohol?	Y	N
Do you feel safe at home?	Y	N