CARAOTTA CHIROPRACTIC ORTHOPEDICS

Lance Myers, DC Nicholas Micka, DC

Chiropractic Case History/Patient Information

Date _____ Patient # _____

Name _____ Birthdate _____ Age _____ Gender: M / F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-mail _____

Marital status: M S W D Number of children ___ **Are you pregnant**? Yes / No Social Security # _____

Occupation _____ Employer _____

Employer's Address _____ Office Phone _____

Spouse _____ Occupation _____ Employer _____

Name of nearest relative and/or emergency contact _____ Phone _____

Who referred you to our office? _____ Primary Care Physician _____

Describe current problem or purpose of this appointment _____

Date symptoms appeared, or accident happened _____

Current complaint (how you feel today):	0	1	2	3	4	5	6	7	8	9	10
	No pain										Unbearable pain

How often are your symptoms present in the past 2 weeks? □ 0-25% □ 26-50% □ 51-75% □ 76-100%

In the past week, how much have your symptoms interfered with your daily activities?

No interference	0	1	2	3	4	5	6	7	8	9	10	Unable to carry on activities

Have you ever had the same or a similar condition? □ Yes □ No If yes, when and describe: _____

_____

Surgeries/Hospitalizations (include year) _____

Serious illness (include year) _____ Allergies: _____

Medications: _____

Please check any and all insurance coverage that may be applicable in this case.

□ Major Medical □ Worker's Compensation □ Medicaid □ Medicare □ Auto Accident □ Other

Name of Primary Insurance Company _____

Name of Secondary Insurance Company (if any) _____

SMS Text Message Consent - We would like to offer you the ability to receive text message reminders for your appointments. Messages are generated by a secure service; however, they are transmitted over a public network to a personal phone. The practice will never transmit any information that would enable an individual patient to be identified. We will NOT send out any texts unless you have explicitly consented. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan.

I CONSENT to the practice contacting me by text message for the purpose of appointment reminders. I will ensure that I keep the practice informed of my up to date mobile number at all times, or if the number is no longer in my possession.

Please initial to consent: _____

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CHECK THE FOLLOWING SYMPTOMS YOU HAVE OR HAD:

GENERAL
□ Allergy
□ Diabetes
□ Dizziness
□ Fainting
□ Fatigue
□ Headache/Migraines
□ Loss of sleep
□ Loss of weight

RESPIRATORY
□ Asthma
□ Chest Pain
□ Chronic Cough
□ Difficulty breathing
□ Wheezing

MUSCLE & JOINT
□ Arthritis
□ Bursitis
□ Low back pain
□ Neck pain or stiffness
□ Pain between shoulders
Pain or numbness in:
□ Shoulders □ Arms
□ Elbows □ Hands
□ Hips □ Legs
□ Knees □ Feet
□ Spinal curvature/Scoliosis
□ Painful tail bone
□ Poor posture
□ Sciatica L__ R__

CARDIO-VASCULAR
□ Hardening of arteries
□ High blood pressure
□ Low blood pressure
□ Pain over heart
□ Poor Circulation
□ Rapid heart beat
□ Slow heart beat
□ Swelling of ankles

SKIN
□ Bruise Easily
□ Dryness
□ Hives or allergies
□ Itching
□ Skin eruptions (rash)

GENITO-URINARY
□ Bed wetting
□ Blood in urine
□ Frequent urination
□ Kidney infection or stones
□ Painful urination
□ Prostate trouble

GASTRO-INTESTINAL
□ Belching or gas
□ Colitis
□ Constipation
□ Diarrhea
□ Difficult digestion
□ Gall bladder trouble
□ Hemorrhoids
□ Nausea
□ Pain over abdomen
□ Poor appetite

EYES, EARS, NOSE & THROAT
□ Deafness
□ Earache
□ Ear noises (tinnitus, etc)
□ Enlarged glands
□ Enlarged thyroid
□ Sinus Infection
□ Sore throat

Have you ever:
□ Been knocked unconscious
□ Had a fractured bone

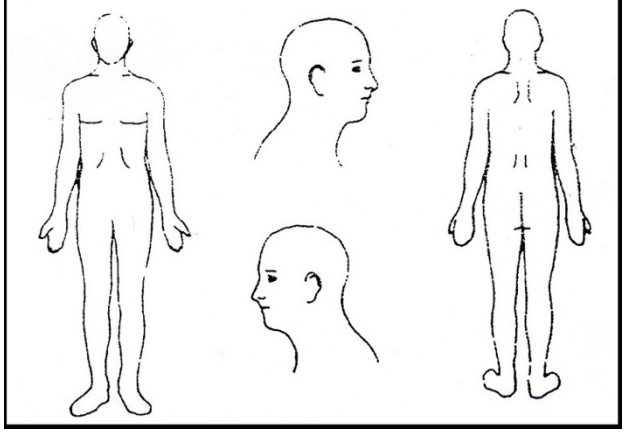
Do you:
□ Now take vitamins or minerals?
□ Think you may need vitamins or minerals?

Height_____ **Weight**_____

Habits (Circle one for each)

Alcohol:	Heavy	Moderate	Casual	None
Coffee (per day):	6	3-6	0-3	None
Smoker:	Former	Current	Never	
Exercise:	Daily	Weekly	None	
Sleep:	Heavy	Moderate	Light	None
Appetite:	Heavy	Moderate	Light	None

Please mark your areas of pain on the figures below.



FAMILY HISTORY:
□ Diabetes □ Stroke □ Cancer □ High Blood Pressure
□ Osteoporosis □ Other _____

(For staff use only)
BP _____/_____ **PULSE**_____

PATIENT AUTHORIZATION REGARDING OUR OPEN DOOR ADJUSTING ENVIRONMENT, SIGN-IN SHEETS, TRAVEL CARD USE AND PATIENT RECORD OF DISCLOSURES.

Our office uses sign in sheets, travel cards, and provides care in an open door adjusting environment. As a result, patients may be in sight of each other, and some ongoing or routine details of care may be in ear shot of other patients and staff. This environment is used for ongoing care and is not the environment for taking patient's histories, performing examinations, or presenting report of findings. These procedures are done in a private, confidential setting. If you choose not to be adjusted in an open door adjusting environment, other arrangements may be made for you. Your signature below authorizes us to contact you at all phone numbers / addresses you list on this intake form. If you do not wish to be contacted at any listed numbers / addresses, please let us know. This office conforms to the current HIPAA guidelines. You may request a copy of our HIPPA policy at the front desk.

By signing below, I affirm that the statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable.

Patients Signature _____**Date**_____

Guardian or Spouse's Signature Authorizing Care _____**Date**_____