WELCOME TO MOUNTAINTOP CHIROPRACTIC

PERSONAL INFORMATION

Name: _____
Address: _____
City_____ State_____ Zip_____
Birthdate: _____
Marital status: _____
Home Phone: _____ Primary: YES NO
Cell Phone: _____ Primary: YES NO
WOULD YOU LIKE TO RECEIVE TEXT MESSAGE APPOINTMENT REMINDERS: YES NO
Emergency Contact: _____
Are you a full-time student?: YES NO
Family Physician: _____
Name of Insurance Carrier: _____
Whom may we thank for referring you?_____

REASON FOR VISIT

Primary reason for today's visit: _____
Is your condition caused by: AUTO ACCIDENT WORK ACCIDENT SPORT INJURY OTHER INJURY
Date your condition started:_____
Describe how your condition/injury happened: _____
_____

PLEASE MARK LOCATION ON DIAGRAM
P=PAIN **N=**NUMBNESS **B=**BURNING

Rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe)
Is your pain: Sharp Dull Stabbing Aching Burning Throbbing
Does your pain radiate? Where? _____
Do you feel pain: Occasionally (up to 25% of the day)
Intermittent (up to 50% of the day)
Frequent (up to 75% of the day)
Constant (up to 100% of the day)
Does your pain interfere with your activities of daily living: _____
If so, explain (house cleaning, sleep, work, etc):_____
_____
What makes your pain worse:_____
_____
What alleviates your pain (ice, heat, meds, etc):_____
_____
Have you seen any other doctors for this condition:_____
_____
Did you have any testing done for this condition (XRAY, MRI,etc):
_____

TO HELP US BETTER UNDERSTAND YOUR CURRENT STATE OF HEALTH, PLEASE COMPLETE THE FOLLOWING PAGE, EVEN IF YOU THINK IT DOES NOT APPLY TO WHAT YOU ARE BEING SEEN FOR TODAY.

Previous Accidents with Dates: _____

_____

Surgeries (with Dates): _____

_____

Hospitalizations (with Dates):_____

_____

Allergies: _____

List ALL medications or vitamins currently taking:_____

_____

DO YOU HAVE ANY CONDITIONS RELATED TO:

[ ] Heart	[ ] Diabetes	[ ] Cancer	[ ] Stroke
[ ] High Blood Pressure	[ ] Thyroid	[ ] Tuberculosis	[ ] Enlarged Prostate
[ ] Kidney	[ ] Asthma	[ ] Ulcer	[ ] Seizure

Other Disorders:_____

Do you smoke: Y N How Much? _____

For Women: Are you taking Birth Control? Y N

Are you pregnant? Y N Are you presently nursing? Y N

Agreement:

I understand it is my responsibility to cover ALL costs billed and such payment is not contingent on payment by my insurance company, settlement, judgement, or verdict by which I might eventually recover. I understand that the office has the right to bill me for a visit if I do not provide 24 hours notice of cancellation. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

REVIEW OF SYSTEMS

PLEASE CHECK ANY SYMPTOMS THAT YOU ARE FEELING, EVEN IF YOU THINK IT DOES NOT APPLY TO YOUR VISIT TODAY. IF NOTHING APPLIES PLEASE CHECK NEGATIVE.

Allergic-Immunologic [ ] Negative

[ ] Hives/Eczema [ ] Hay Fever [ ] Catch Colds Easy [ ] Frequent Sinus Trouble
[ ] Frequent Influenza [ ] HIV [ ] AIDS [ ] Allergies [ ] Fever

Cardiovascular [ ] Negative

[ ] Murmur [ ] Chest Pain [ ] Palpitations [ ] Dizziness [ ] Shortness of Breath [ ] Swollen Ankles
[ ] Heart Attack [ ] Irregular Heartbeat [ ] Pressure Over the Chest [ ] Pain Down Left Arm
[ ] High Triglycerides [ ] High Cholesterol Levels [ ] Profuse Sweating [ ] Nausea [ ] Vomiting
[ ] Low Blood Pressure [ ] Fainting Spells [ ] High Blood Pressure [ ] Difficulty Lying Flat

Constitutional [ ] Negative

[ ] Weight Loss [ ] Fatigue [ ] Fever

Ear/Nose/Throat [ ] Negative

[ ] Difficulty Hearing [ ] Buzzing In Ears [ ] Ringing In Ears [ ] Vertigo [ ] Sinus Trouble
[ ] Nasal Stuffiness [ ] Hearing Loss [ ] Ear Pain [ ] Mouth Sores [ ] Hoarseness [ ] Nose Bleeds
[ ] Dental Problem [ ] Frequent Sore Throat [ ] Difficulty Swallowing

Endocrine [ ] Negative

[ ] Loss of Hair [ ] Heat/Cold Intolerance [ ] Hypothyroidism [ ] Hyperthyroidism [ ] Diabetes [ ] Goiter

Eyes [ ] Negative

[ ] Glasses/Contacts [ ] Eye Pain [ ] Light Bothers [ ] Double Vision [ ] Cataracts [ ] Vision Problems
[ ] Blurred Vision [ ] Glaucoma

Gastro-intestinal [ ] Negative

[ ] Heartburn/Reflux [ ] Nausea/Vomiting [ ] Constipation [ ] Change in BM's [ ] Diarrhea
[ ] Black/Bloody Stools [ ] Gallbladder Problem [ ] Liver Problem [ ] Hepatitis [ ] Greasy Food Bothers
[ ] Ulcers [ ] Hiatal Hernia [ ] Colitis [ ] Colon Cancer [ ] Abdominal Pain [ ] Burning in Stomach
[ ] Pancreatitis [ ] Jaundice [ ] Pain over Stomach [ ] Mucus in Stool

Genitourinary [ ] Negative

[ ] Burning/Frequency [ ] Blood in Urine [ ] Erectile Dysfunction [ ] Abnormal Discharge [ ] Leakage
[ ] Incontinence [ ] Kidney Infection [ ] Sexual Difficulty [ ] Kidney Stones [ ] Loss of Libido

Hematology/Lymph [ ] Negative

[ ] Easy Bruising [ ] Gums Bleed Easy [ ] Enlarged Glands [ ] Anemia [ ] Bleeding Disorder
[ ] Sickle Cell Anemia [ ] Lymphoma

OVER →

Musculoskeletal [ ] Negative

[ ] Joint Pain/Swelling [ ] Stiffness [ ] Muscle Pain [ ] Neck Pain [ ] Stiff Neck [ ] Back Pain
[ ] Osteoarthritis [ ] Rheumatoid Arthritis [ ] Bone Spurs [ ] Broken Bones [ ] Compression Fracture
[ ] Head Injury [ ] Back Injury [ ] Spinal Trauma [ ] Birth Trauma [ ] Birth Defects [ ] Cancer
[ ] Muscle Weakness [ ] Muscular Dystrophy [ ] Sheuerman's Disease [ ] Scoliosis [ ] Lupus
[ ] Spina Bifida [ ] Spondylolisthesis [ ] Arthritis [ ] Neck Injury [ ] Osteoporosis

Neurological [ ] Negative

[ ] Loss of Strength [ ] Numbness [ ] Headaches [ ] Heavy Head [ ] Tremors [ ] Memory Loss
[ ] Difficulty Speaking [ ] Multiple Sclerosis [ ] Parkinson's Disease [ ] Fainting [ ] Concussion
[ ] Migraines [ ] Disorientation [ ] Loss of Coordination [ ] Difficulty Walking [ ] Stroke [ ] Alzheimer's
[ ] Weakness [ ] Disc Problem [ ] Lightheaded/Dizzy [ ] Epilepsy/Seizure [ ] Tingling

Psychiatric [ ] Negative

[ ] Anxiety [ ] Depression [ ] Mood Swings [ ] Difficulty Sleeping [ ] Nervousness [ ] Tension

Respiratory [ ] Negative

[ ] Cough [ ] Coughing Blood [ ] Wheezing [ ] Chills [ ] Chronic Cough [ ] Pneumonia [ ]Asthma
[ ] Superficial Breathing [ ] Chest Pain [ ] Tuberculosis [ ] Bronchitis [ ] Emphysema
[ ] Difficulty Breathing [ ] Lung Cancer

Integumentary (Skin) [ ] Negative

[ ] Rash/Sores [ ] Lesions [ ] Itchng/Burning [ ] Skin Problem [ ] Slow Healing [ ] Bruise Easily
[ ] Psoriasis [ ] Change in Moles [ ] Change in Skin Color [ ] Skin Cancer [ ] Scars [ ] Discolorations

Other [ ] Negative

_____

Men's Health Issues [ ] Negative

[ ] Burning on Urination [ ] Difficulty in Starting Urine [ ] Dripping Urination [ ] Prostate Trouble
[ ] Prostate Cancer

Women's Health Issues [ ] Negative

[ ] Hot Flashes [ ] Vaginal Discharge [ ]Nipple Discharge [ ] Menstrual Cramps [ ]Lumps in Breast
[ ]Premenstrual depression [ ] Hysterectomy

General [ ] Negative

[ ] Recent Weight Gain [ ] Loss of Sleep [ ] Loss of Appetite [ ] Fatigue [ ] Polio
[ ] Rheumatic Fever [ ] Cancer of Any Kind