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 _____

Who is your primary care provider and clinic? _____

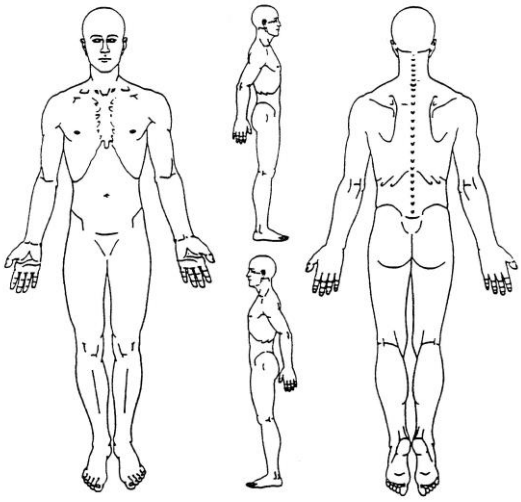
Marital Status:

☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

Height ____ Ft. ____ In. Weight ____ Lbs.

What brings you in to the clinic today?

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



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What is your primary complaint? _____

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 wakes you up at night/night sweats N Y, Explain: _____

Unexpected weight loss or gain N Y, Explain: _____

Worst headaches of your life N Y, Explain: _____

Vomiting and/or blood loss 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? _____

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

Lying down Walking Standing Sitting

Movement/Exercise Inactivity Bending Coughing/Sneezing

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Who else have you seen for this complaint? _____

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

What are your goals for treatment? _____

List any other complaints in order of severity:

_____

Health History

Medications/supplements: _____

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?** _____

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 an immediate family history of any of the following illnesses/diseases?

Heart Disease	M/F/GM/GF	Asthma	M/F/GM/GF
Hypertension	M/F/GM/GF	Cancer	M/F/GM/GF
Stroke	M/F/GM/GF	Migraines	M/F/GM/GF
Arthritis	M/F/GM/GF	Back Problems	M/F/GM/GF
Diabetes	M/F/GM/GF	Lung Disease	M/F/GM/GF

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

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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, floaters, double vision, light sensitivity, etc.

_____

Significant *ear* complaints such as: loss of hearing, ringing, 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