



# General Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_

Phone: \_\_\_\_\_  Cell  Home

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

How did you hear about/find us? \_\_\_\_\_

Is this your first visit to a Chiropractic Physician?

No  Yes

## Emergency Contact Info

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_  Cell  Home

Dr.'s Notes

# Reason for Visit

What brings you in today? \_\_\_\_\_

Have you received treatment for this condition in the past?

No  Yes

If yes, where? \_\_\_\_\_

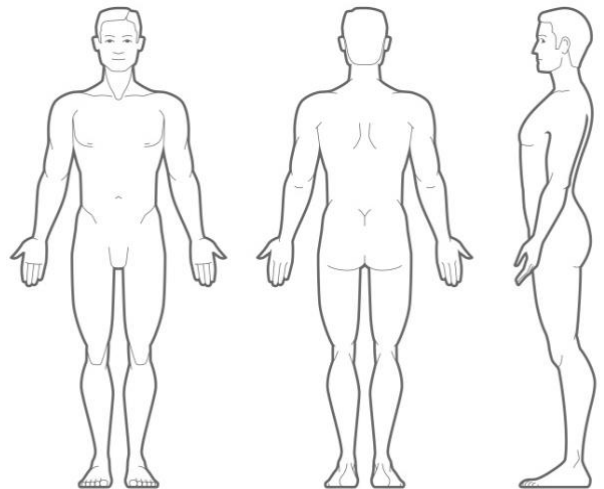
When? \_\_\_\_\_

Are you seeking treatment related to an accident?

Auto  Work  Other  No

Using the symbols below, please mark any areas where you're experiencing:

x Pain    ⊙ Numbness or Tingling    # Burning



How severe is your pain on a scale of 0 to 10:

On Average? \_\_\_\_\_ At worst? \_\_\_\_\_ At best? \_\_\_\_\_

Check the boxes that best describe your symptoms:

Constant  Comes & goes  Worse at night

Worse in the morning  Sharp  Dull

Aching  Shooting  Throbbing

When did your symptoms first appear? \_\_\_\_\_

What (if anything) makes it better? \_\_\_\_\_

What makes it worse or irritates it? \_\_\_\_\_



# Health History

**Recent signs & symptoms:** (Please check all that apply.)

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Constant Pain         | <input type="checkbox"/> Unexplained Weight Loss/Gain | <input type="checkbox"/> Loss of Bladder Control    | <input type="checkbox"/> Abnormal Bleeding    |
| <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Excessive Thirst             | <input type="checkbox"/> Frequent/Painful Urination | <input type="checkbox"/> Excessive Bruising   |
| <input type="checkbox"/> Fever, Chills, Sweats | <input type="checkbox"/> Nausea/Vomiting              | <input type="checkbox"/> Blood in Urine             | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Change in Appetite    | <input type="checkbox"/> Severe Abdominal Pain        | <input type="checkbox"/> Black/Bloody Stools        | <input type="checkbox"/> Tightness in Chest   |

Are you currently pregnant?  No  Yes, Due Date: \_\_\_\_\_

**Have you ever had any of the following conditions?**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Recurring Sinusitis     | <input type="checkbox"/> Disc Herniation/Bulge |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Pacemaker                | <input type="checkbox"/> Bloating                | <input type="checkbox"/> Arthritis             |
| <input type="checkbox"/> Bleeding Disorder      | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Belching/Gas            | <input type="checkbox"/> Osteoporosis          |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Swelling in Ankles/Legs  | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Rheumatoid Arthritis  |
| <input type="checkbox"/> Clotting Disorder      | <input type="checkbox"/> Allergies                | <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Latex Allergy         |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Depression              | <input type="checkbox"/> Psoriasis             |
| <input type="checkbox"/> Heart Attack           | <input type="checkbox"/> Recurring Ear Infections | <input type="checkbox"/> Drug/Alcohol Dependency | <input type="checkbox"/> Sprained Ankle        |

**Please list any injuries, hospitalizations or surgeries, with approximate dates:** (broken bones, appendicitis, etc...)

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## Medications

## Vitamins

## Allergies

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dr.'s Notes



# Lifestyle

## Exercise

- None
- Minimal
- Moderate
- Daily
- Excessive

## Work Activity

- Sitting
- Standing
- Light Labor
- Medium Labor
- Heavy Labor

## Habits

- Smoking Frequency: \_\_\_\_\_
- Alcohol Frequency: \_\_\_\_\_
- Recreational Drugs Type: \_\_\_\_\_
- Coffee/Caffeine Frequency: \_\_\_\_\_
- High Stress Reason: \_\_\_\_\_

## Nutrition

How would you describe your eating habits?

- I eat whatever and whenever I want.
- I make an attempt to eat right, but struggle.
- Most of the time I eat right, but treat myself on occasion.
- I strictly regulate my food intake, all the time.
- I'm all over the board. No consistency

## Sleep

Average hours of sleep per night? \_\_\_\_\_

I normally sleep on my:

- Back
- Stomach
- Side
- Toss & Turn

# Authorization to Provide Care

I authorize the physicians at Upright Health Muscle & Joint Care to administer manual manipulations, advanced soft tissues techniques, passive therapies and/or any treatment they deem appropriate, for the purposes of regaining and/or maintaining musculoskeletal health, unless I expressly refuse beforehand.

Initial: \_\_\_\_\_

# Receipt of Notice of Privacy Practices

I have been offered a copy of Upright Health Muscle & Joint Care's Notice of Privacy Practices, which provides an explanation of my rights with respect to my personal health information and the privacy practices of this clinic, in accordance with the Health Insurance Portability & Accountability Act (HIPAA) of 1996. I understand I can review this notice anytime at [www.uprighthealth.us/npp.pdf](http://www.uprighthealth.us/npp.pdf)

Initial: \_\_\_\_\_

# Payment Policy

I understand that payment for services rendered, per the fee schedule listed at <http://uprighthealth.us>, will be due on the date of service and accepted in the forms of cash, check or charge. I may choose to submit a reimbursement claim directly to my insurance provider. UprightHealth will supply any additional documentation regarding my treatment, needed for this purpose, at my request.

Initial: \_\_\_\_\_