Family Chiropractic of Round Rock

Date___________________________ Whom may we thank for referring you? ___________________________________

Name: ____

Address: ____

City: ___________________________ State: ____________ Zip: _________________________

Home Phone: ______-______-_______Work Phone: ______-______-_______ Cell Phone: ______-______-___________

Email Address: _____________________________________ Occupation: _____________________________________

Date of Birth: ________________________Age________________ Gender: Male________ Female_______

Marital Status: ☐ Single ☐Married ☐Divorced ☐Widowed ☐Separated

Allergies:

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs☐ Latex ☐ Molds ☐ Penicillin

☐ Ragweed/Pollen ☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat ☐ X-Ray Dye

☐Food Coloring/Dyes ☐Other:_____________________________

Surgeries:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist

☐ Other: _________________________________ Dates/Year:___________________________________

ALL **Past Medical History** conditions: (Please check all that apply)

☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain

☐ Depression ☐ Diabetes ☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting

☐ Fatigue ☐ Foot Pain ☐ Genetic Spinal Condition ☐ Hand Pain ☐ Headaches ☐ Hearing Problems

☐ Hepatitis ☐ High Blood Pressure ☐ Hip Pain ☐ HIV ☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain

☐ Menstrual Problems ☐ Mid-Back Pain ☐ Heart Problems ☐ Multiple Sclerosis ☐ Neck Pain

☐ Neurological Problems ☐ Pacemaker ☐ Parkinson's☐ Polio ☐ Prostate Problems ☐ Shoulder Pain

☐ Significant Weight Change ☐ Spinal Cord Injury ☐ Sprain/Strain ☐ Stroke/Heart Attack

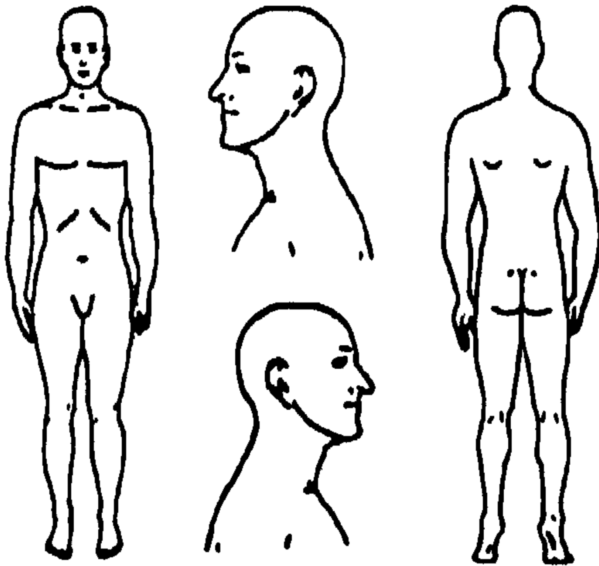
☐ Other: ____

Family History:

☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Cancer ☐ Depression ☐ Diabetes ☐ Epilepsy ☐ Genetic Spinal Condition ☐ High Blood Pressure ☐ Heart Problems ☐ Neurological Problems ☐ Parkinson's

☐ Stroke/Heart Attack ☐ Other: ____

PLEASE MARK YOUR AREAS OF PAIN OR SYMPTOMS ON THE DIAGRAM BELOW



WHAT ARE YOUR HEALTH GOALS?

- ☐ Become pain free
- ☐ Explanation of my condition
- ☐ Learn how to care for my condition
- ☐ Reduce symptoms
- ☐ Resume normal activity level

HOW WOULD YOU RATE YOUR CURRENT HEALTH?

1 2 3 4 5 6 7 8 9 10
Near death **Healthy**

WHERE WOULD YOU LIKE TO BE?

1 2 3 4 5 6 7 8 9 10
Near death **Healthy**

What is your reason for this visit? ____

Date problem began? _____________________

How did this problem begin (car accident, falling , lifting?) ____

How is your condition changing? ☐ **GETTING BETTER** ☐ **GETTING WORSE** ☐ **NOT CHANGING**

Have you had this condition in the past? ☐ YES ☐ NO

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your pain: ☐Achy ☐ Burning ☐ Numb ☐ Tingling ☐ Shooting ☐ Stabbing ☐ Radiating ☐ Dull ☐ Tightness ☐ Sharp ☐ Throbbing ☐ Stiff ☐ Other: ____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

Today ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**   Last week ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

What normal daily activities can you Not perform? ____

What activities makes your condition worse (sitting, standing, exercise, etc)? __________________________________

What makes your pain better (ice, heat, massage, etc)? ____

Have you ever been to a Chiropractor? If so, when and why. ____

Have you received treatment for this condition? ☐Medication ☐Surgery ☐Physical Therapy ☐Chiropractic Services ☐ Acupuncture ☐None ☐Other____

List Type of **Medications** you are taking:

☐ Allergy ☐ Anti-inflammatory ☐ Anxiety ☐Blood Pressure ☐ Cardiovascular ☐ Insulin ☐ Muscle Relaxers

☐ Pain Killers ☐ Seizure ☐ Other: ____

☐ Supplements/Nutrition____

Previous Injuries

Have you had any auto or other accidents? ☐ No ☐Yes Did you have treatment? ☐ No ☐Yes

Describe: ____

____

Date of last physical examination: __________________

Have you had ☐ X-rays ☐CT Scan ☐ MRI List reason and date ______________________________________

Do you smoke? ☐ No ☐Yes How many per day?________

Do you drink alcohol? ☐ No ☐Yes - how many per day/week? __________________

Do you drink caffeine? ☐ No ☐Yes - how many per day? __________________

Do you exercise? ☐ No ☐Yes (what forms and how often): ____

Are you pregnant? ☐No ☐Yes

Insurance Information:

Name on policy ______________________________________
Insurance Co. ______________________________________
Employer of Insured __________________________________

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with ________________________ and assign directly to Dr. Milne all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____ ____
Signature of Patient, Parent or Guardian Please print name of Patient, Parent or Guardian

____ ____
Date Relationship to Patient