ROGERS CHIROPRACTIC CENTER

NEW PATIENT

We are pleased to welcome you to our practice. To save time and allow us to better serve you, please complete all the information required. If you have any questions, we will be happy to help.

TODAYS DATE:				
1. Name (Last, First, Middle Initial)	2. Sex ☐M ☐F	3. Social Security # - -	4. Age	5. Date of Birth / /
6. Address City State Zip			7.E-mail Address	
8. Home Telephone	9. Cell Phone	10. Work Phone		11. Which phone would you like to be contacted on? ☐Home ☐Work ☐Cell
12. Occupation	13. Employer		14. # of Children	
15. Marital Status ☐Single ☐Married ☐Divorced ☐Widow	16. Employers Address		17. Name(s) & Age(s) of Children	
	18. Name of Spouse		19. Do your Children have any Health Problems?	
20. Are you Pregnant? ☐Yes ☐No ☐Maybe	21. Does your Spouse have any Health Problems?		22. Do you have Health Insurance? ☐Yes ☐No Company's Name: Subscriber Name: Subscriber Birthday: / / Relationship to Subscriber:	
23. Have you had Chiropractic Care Before? ☐ Yes ☐No Where? When?	24. Referred By:			
	25. Name and Telephone # of Emergency Contact			

26. Have you ever had any accidents, injuries, or major falls?	Month, Year	Type	Describe Injury
27. Have you ever had any surgery?	Month, Year	Type	Describe Injury
28. Are you currently taking any medication?	Month, Year	Type	Reason for Taking it
29. Are you currently taking any Nutritional Supplements?	Month, Year	Type	Reason for Taking it

Health History

Check any of the following conditions that you have had within the last year.

MUSCULO-SKELETAL
- ☐ Arthritis
- ☐ Arms/Hands Pain
- ☐ Hip Pain
- ☐ Jaw Problems
- ☐ Joints Pain
- ☐ Legs/Feet Pain
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Osteoporosis
- ☐ Shoulder Pain/Tightness
- ☐ Stiffness

NERVOUS
- ☐ Face Twitching
- ☐ Fainting
- ☐ Nervousness
- ☐ Numbness/Tingling
- ☐ Pinched Nerve
- ☐ Seizures/Convulsions
- ☐ Tremors

FEMALE (ONLY)
- ☐ Breast Pain/Lumps
- ☐ Menstrual Cramps
- ☐ Menstrual Irregularity
- ☐ Vaginal Pain/Infections

C-V-R
- ☐ Ankle Swelling
- ☐ Asthma
- ☐ Blood Pressure Problems
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ High Cholesterol
- ☐ Shortness of Breath

GASTRO-INTESTINAL
- ☐ Abdominal Pain/Cramps
- ☐ Black/Bloody Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Thirst
- ☐ Frequent Nausea/Vomiting
- ☐ Heartburns
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Poor Appetite
- ☐ Ulcers

GENITO-URINARY
- ☐ Bed Wetting
- ☐ Bladder Problems
- ☐ Discolored Urine
- ☐ Excessive Urination
- ☐ Painful/Burning Urination

EENT
- ☐ Ear/Hearing Problems
- ☐ Ear Infections
- ☐ Eye/Vision Problems
- ☐ Nose/Smelling Problems
- ☐ Sinus Problems
- ☐ Throat Problems

SKIN
- ☐ Itching/Rash
- ☐ Skin Problems
- ☐ Tumors/Cysts/Lumps

GENERAL
- ☐ Allergies
- ☐ Cold Sweats
- ☐ Depression
- ☐ Dizziness
- ☐ Difficulty Sleeping
- ☐ Fatigue
- ☐ Headaches
- ☐ Memory Problems
- ☐ Sudden Loss of Weight
- ☐ Swelling

MALE (ONLY)
- ☐ Genital Problems
- ☐ Prostate Problems

Check any of the following diseases that you have had in your life.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Bulimia
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Disc Herniation
- ☐ Gout
- ☐ Hayfever
- ☐ Heart Problems
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Measles
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Polio
- ☐ Shingles
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Whooping Cough

Family History

Check any of the following family members that had any of the diseases mentioned above.

- ☐ Father:____________________
- ☐ Mother: ____________________
- ☐ Brother: ____________________
- ☐ Sister: ____________________
- ☐ Spouse: ____________________
- ☐ Child: ____________________
- ☐ Uncles/Aunts: ____________________
- ☐ Grandparents: ____________________

Patient Name:____ Date:____________________

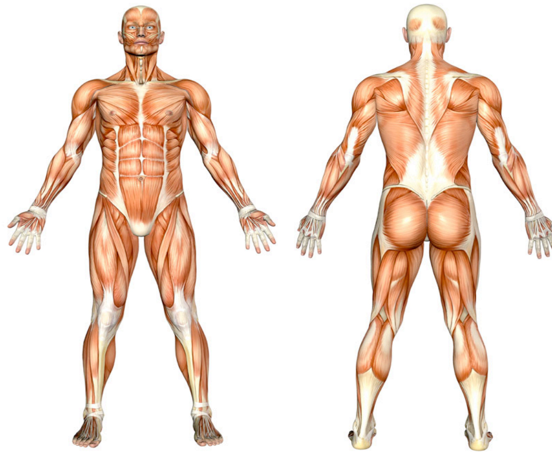
Your Current Condition

Patient Name: ____ Date:____________

1. Chief Complaint: ____

2. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation ☐ Other

3. Indicate on the drawings below where you have pain/symptoms



4. How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)
☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

5. How would you describe the type of pain?

☐ Sharp ☐ Shooting ☐ Shooting with Motion
☐ Dull ☐ Stiff ☐ Stabbing with Motion
☐ Diffuse ☐ Numb ☐ Electric like with Motion
☐ Achy ☐ Tingly ☐ Other:_________________
☐ Burning ☐ Sharp with Motion

6. How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐Getting Better

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem? (Please Circle)

0 1 2 3 4 5 6 7 8 9 10

8. How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

10. Who else have you seen for your problem?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
☐ ER Physician ☐ Orthopedist ☐ Other:______________
☐ Massage Therapist ☐ Physical Therapist ☐ No one

11. How long have you had this problem? ____

12. How do you think your problem began? ____

13. Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No

14. What aggravates your problem? ____

15. What concerns you the most about your problem; what does it prevent you from doing?_______________

____

16. What is your: Height___________ Weight______________ Occupation_______________

17. How would you rate your overall health? ☐ Excellent ☐ Very Good ☐ Fair ☐Poor

18. What type of exercise do you do? ☐ Strenuous ☐ Moderate ☐ Light ☐ None

19. What activities do you do at work?

Sit:	☐ Most of the day	☐ Half the day	☐ A little of the day
Stand:	☐ Most of the day	☐ Half the day	☐ A little of the day
Computer Work:	☐ Most of the day	☐ Half the day	☐ A little of the day
On the phone:	☐ Most of the day	☐ Half the day	☐ A little of the day

20. What activities do you do outside of work? ____

____

21. Have you ever been hospitalized? ☐ Yes ☐ No

If yes, why? ____

22. Anything else pertinent to your visit today?

____

I certify that I have read, understood, and answered the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

____

Signature of Patient (or parent if minor) Date

Authorization

I authorize Rogers Chiropractic Center to release any information concerning my condition to any insurance company, attorney, or health practitioner. I authorize direct payment to Rogers Chiropractic Center for any sum that I owe now or in the future; from any insurance company that is obligated to reimburse me for changes incurred in your office, or my attorney out of the proceeds of my settlement. A photocopy of this form is acceptable for payment. I herby assign and give to Rogers Chiropractic Center the right to take action against any insurance company that is obligated by contract to make payment to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf, or my dependants, and pay it within a 90 day period. I understand that in the event that my account is past due, I will be charged and I will be responsible for an additional $20.00 fee.

____

Signature of Patient (or parent if minor) Date

____

Signature of Witness Date

Consent For Treatment & X-ray Policy

It is understood and agreed upon that the amount paid at Rogers Chiropractic Center for x-rays is for examination only. X-ray negatives will remain the property of this office, and could be seen at any time while the person is still a patient at this office. A copy of the x-rays may be provided for a fee. I herby authorize Dr. Dayne Rogers, and whomever he may designate as his assistant, to administer treatment to me and my dependants as he so deems necessary.

Is it possible that you are pregnant? ☐ **Yes** ☐ **No**

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Signature of Patient (or parent if minor) Date

____

Signature of Witness Date