Apex Spine Center Patient General Information Questionnaire

Thank you for visiting our office today! We are committed to serve our community in a professional clinical environment and to empower our patients to actively take charge of their own health. In our office, we recognize and respect our body as a self-developing, self-maintaining, and self-healing living organism.

If you have been involved in an auto accident or a work injury please speak to one of the office assistants before you fill out this form.

First Name _____ Last Name _____ M.I _____

Prefer to be called _____ Date of Birth _____ [ ] M [ ] F

Patient or Guardian's Name (if patient is a Minor) _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____Work: _____Mobile: _____

Email: _____ SS# _____

Job Description: _____

Place of Employment: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Spouse/Partner Name: _____ Number of Children: _____ Ages: _____

Emergency Contact Person: _____ Phone: _____

[FEMALE ONLY] Are you currently pregnant? [ ] Yes [ ] No [ ] Maybe [ ] N/A

If you were referred, whom may we thank?

Whom may we discuss your health information with?

1) _____ 2) _____

3) _____ 4) _____

Signature: _____ Date: _____

Are you here for specific condition? [ ] Yes [ ] No If No, please go directly to next page.

Chief Complaint 1:

- **Briefly describe your complaint:**
  _____
- **Pain scale:** (best) 0 1 2 3 4 5 6 7 8 9 10 (worst)
- **What kind of pain**

[ ] Sharp [ ] Dull [ ] Ache [ ] Sore [ ] Numbness/Tingling
[ ] Pinching [ ] Tightness/Spasm [ ] Burning

- **It is** [ ] Constant [ ] Comes & Goes

It is better in: [ ] Morning [ ] Afternoon [ ] Evening

- **Check all that aggravate your condition:**

[ ] Driving [ ] Walking [ ] Sitting [ ] Exercising [ ] Standing
[ ] Bending [ ] coughing [ ] breathing [ ] Bowel movements
[ ] Other: _____

- **Check all that make your condition better:**

[ ] Resting [ ] Stretching [ ] Sitting [ ] Standing [ ] Exercising [ ] Massage
[ ] Chiropractic [ ] Medication [ ] Recumbent [ ] Nothing
[ ] Other: _____

- **Have you had this condition before?** [ ]Yes [ ] No If Yes, When:_____
- **Have you seen any other healthcare provider for your current condition?** [ ] Yes [ ] No

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Chief Complaint 2:

- **Briefly describe your complaint:**
  _____
- **Pain scale:** (best) 0 1 2 3 4 5 6 7 8 9 10 (worst)
- **What kind of pain**

[ ] Sharp [ ] Dull [ ] Ache [ ] Sore [ ] Numbness/Tingling
[ ] Pinching [ ] Tightness/Spasm [ ] Burning

- **It is** [ ] Constant [ ] Comes & Goes

It is better in: [ ] Morning [ ] Afternoon [ ] Evening

- **Check all that aggravate your condition:**

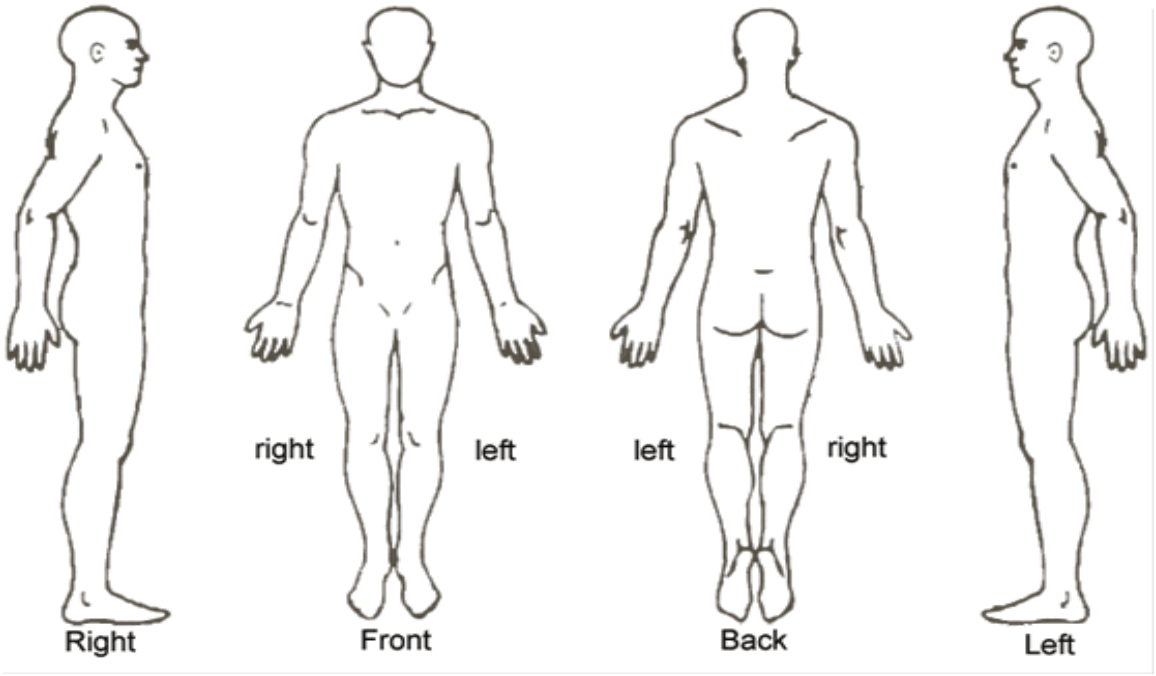
[ ] Driving [ ] Walking [ ] Sitting [ ] Exercising [ ] Standing
[ ] Bending [ ] Coughing [ ] Breathing [ ] Bowel movements
[ ] Other: _____

- **Check all that make your condition better:**

[ ] Resting [ ] Stretching [ ] Sitting [ ] Standing [ ] Exercising [ ] Massage
[ ] Chiropractic [ ] Medication [ ] Recumbent [ ] Nothing
[ ] Other: _____

- **Have you had this condition before?** [ ]Yes [ ] No If Yes, When:_____
- **Have you seen any other healthcare provider for your current condition?** [ ] Yes [ ] No

Please mark the areas of your conditions



S= Sharp, N= Numb, P= Pinch, B= Burning, A= Ache

Review of Systems

Please mark <u>all</u> conditions that you have currently or have had in the past.

C = Current P = Past If none of the following apply, please check here [ ]

Muscle/Joint	**ERT/Internal/Dig-estive**	**Cardiovascular** C P	**Pulmonary** C P	**General**
Arthritis C P	Thyroid C P	Blood Pressure C P	C.O.P.D. C P	Food Allergy C P
Back Pain C P	Hearing C P	Irregular HR C P	Asthma C P	Dizziness C P
Sciatic Pain C P	Vision C P	Poor Circulation C P	Seasonal Allergy C P	**Infectious Disease**
Hip Pain C P	Ear Infection C P	**Urinary/Reproductive**	**Skin**	HIV C P
Foot Pain C P	Stomach C P	UTI C P	Psoriasis C P	Hepatitis C P
Neck Pain C P	Intestinal C P	Prostate C P	Varicose C P	TB C P
Headache C P	Colon C P	Kidney C P	Skin Allergy C P	**Endocrine** C P
Shoulder Pain C P	Liver C P	Pregnancy C P	Hives C P	**Neurological** C P
Arm Pain C P	Gall Bladder C P	Menstrual C P	Easy Bruising C P	**Psychological** C P
Wrist Pain C P	Pancreas C P	Venereal Disease C P		
		Difficulty Urinating C P		

Are you taking any medications and supplements? If (YES), please list:

_____

_____

Past Health History:

- Accidents, Injuries, Fractures (Dates) _____

_____

- Surgeries (Dates)

_____

_____

- Hospitalizations (Dates) _____

_____

Family History of any health conditions:

_____

_____

Life Style:

- Do you drink alcohol? [ ] Yes How many per day or per week? _____ [ ] No
- Do you smoke or using any tobacco product?
  [ ] Yes How many per day or per week? _____ [ ] No
- Do you exercise? [ ] Yes How often? _____ [ ] No
- Type of exercise (circle ones that apply)
  Stretching/ Flexibility Running/ Treadmill/ Walking Swimming/ Rowing
  Competitive athlete Pilates/ Yoga Weight Lifting Triathlon/ Iron man others:_____
- Sleep hours and quality: _____ hours / day, Excellent Good Fair Poor (circle one)

Your health is affected by your nervous system. The food you eat, environment surrounding you and life style also play important roles in your health. Take charge of your health!

Consent for Chiropractic Care in Apex Spine Center

Chiropractic care is based on clinical evidence of vertebral subluxations and **not** the presence or absence of pain, abnormal range of motion, or abnormal spinal curves. By the use of specific analysis and spinal and/or extremity adjustments, the goal of chiropractic is primarily to reduce/correct spinal subluxations.

- In some situations, your care will occur in an open environment and personal health information (PHI) may be subject to incidental exposure by others in the clinic setting.
- I understand that my records and/or x-rays are the property of Apex Spine Center and will be used for teaching and research purpose and if at anytime I request a copy of my records and/or x-rays there will be an additional charge for copying them.
- I authorize Apex Spine Center and its agents to administer care as needed, as indicated from examination findings.
- I authorize Apex Spine Center to release information to my doctor and/or insurance company.
- I understand that if I am in the litigation for any accident me settlement may be jeopardized by the fact that a student is rendering my care in the clinic. (student interns can treat me only if Apex Spine Center informs me prior with my consent)
- A parent or an approved individual MUST accompany their minor child on every visit to the clinic.
- I acknowledge that I have read Apex Spine Center's Notice of Privacy Practices and acknowledge that I may have a personal copy of the entire Notice upon request.
- I consent to the use and/or disclosure of my protected health information as specified in Apex Spine Center's Notice of Privacy Practices.

I have read and understand the above.

_____ _____ _____

Patient signature **Relationship to Patient** **Date**

(Custodial parent or legal guardian if patient is a minor)

_____ _____ _____ _____

Witness Signature **Date** **Doctor's signature** **Date**

Patient Category
❑ Cash
❑ Insurance
❑ Children
❑ Free care
❑ Staff
❑ Staff Family
❑ Student
❑ Student Family
❑ Teacher/fireman/police
❑ Active Military/Veteran

Do Not Write Below This Line