SYMMETRY CHIROPRACTIC AND PHYSICAL THERAPY

Patient Information

Please fill out the below information as thoroughly as possible. Mark N/A in any required fields if unknown.

Name:_______________________________________Today's Date:____________________

Address:____

City:______________________________State:_____Zip:_________ Cell Phone:____________________

Work Phone:_________________Social Security Number:_________________Date of Birth:__________

Marital Status:________________________ Spouse's Name:______________________________

Email:_______________________________ How did you hear about us?:____________________

If referred, who referred you to our office?:____

Employer's Name and Address:____

Primary Care Physician Name:___________________________Clinic:______________________

Phone:______________________ Address:____

Present Health Condition

In order of importance, list the health problems you are most interested in getting corrected:

1)__________________________________

2)__________________________________

3)__________________________________

List approximately how long you have noticed these problems:

1)__________________________________

2)__________________________________

3)__________________________________

Is there a certain time of day any of these problems are better or worse?

____

____

List the treatments you have used for these problems:

□ Ice □ Heat □ Exercise □ Massage □ Chiropractic □ Rest

□ Physical Therapy □ Medication(s):_______________

____

□ Other:______________________________

Describe any sudden movements, injuries, falls, accidents, etc. that have caused your problem(s):_______________

____

Have you had similar health problems or injuries before? □Yes □No

Did you receive: X-Rays □ Yes □ No Date:__________ MRI □ Yes □ No Date:__________

Have your health problems: □ Improved □ Worsened □ Stayed the Same

List anything that makes your conditions worse: ___________________________________

List anything that makes your conditions better: ___________________________________

Please check off and describe how this problem interferes with your work and/or personal life:

□ Work Activities Effected: ___________________________________

Have you missed any days of work? □Yes □No If yes, dates missed: ____________________

□ Home Activities Effected: ___________________________________

□ Recreational Activities Effected: ___________________________________

Social History

Do you smoke? □ Yes □ No If yes, how many packs/daily: _____

Do you drink? □ Yes □ No If yes, how many drinks/week: _____

Do you exercise regularly? □ Yes □ No If yes, describe what type and how often: ____________________

____

Do you consider yourself to have a good social support system (friends/family)? □ Yes □ No

Describe a typical daily diet (fast food/home cooked/vegan/gluten free/specific diet plan/etc.):

____

Review of Systems

Check any symptoms you've had in the past year:

□ Muscle Pain	□ Fever	□ Chills	□ Fatigue	□ Eye pain	□ Blurred vision
□ Double vision	□ Headaches	□ Joint swelling	□ Nosebleed	□ Ringing in ears	□ Chest pain
□ Skin changes	□ Fainting	□ Wheezing	□ Chest tightness	□ Anxiety	□ Heartburn
□ Nausea	□ Vomiting	□ Constipation	□ Diarrhea	□ Bloody stool	□ Joint stiffness
□ Difficult/ painful urination	□ Unexpected weight loss or gain	□ Difficulty swallowing	□ Heart Palpitations	□ Poor wound healing	□ Shortness of breath
□ Depression	□ Tremors	□ Seizures	□ Easy bleeding/ bruising	□ Excessive thirst or urination	□ Allergic Reactions
□ Tingling	□ Numbness	□ Sleep Disorder			

Past Health History

During the last year, has a doctor treated you for any health problem? ◻Yes ◻No

If yes, please explain:____

____

Please check the prescription drugs you are currently taking: ◻Anti-depressants ◻Anti-Inflammatory

◻ Birth Control Pills ◻ Blood Pressure Pills ◻ Diet Pills ◻ Blood Sugar Medication

◻ Muscle Relaxers ◻ Insulin ◻ Pain Pills ◻ Sleeping Pills

◻ Aspirin ◻ Tylenol ◻ Motrin ◻ Aleve ◻ Advil

◻ Other (please list):____

List any vitamins or nutritional supplements you are currently taking or have taken recently:

____

List the approximate dates of any surgeries, serious injuries, or accidents (including broken bones) you have had:

____

____

Please list any chronic health problems that run in your family:

____

____

Financial Responsibility

Who is responsible for your bill? ◻ Insurance ◻ My Employer ◻ Spouse ◻ I am

◻ Other:

Type of Insurance: ◻ Automobile ◻ Health ◻ Worker's Comp

Insurance Company's Name, Address and Phone #: ____

____

Your fees are due and payable at the time examination, X-rays and treatments are received, unless other arrangements have been made in advance. X-rays remain property of this clinic.

I, the undersigned, hereby give permission for treatment.

Patient's Signature:__________________________________ Date: ___________

Parent or Guardian Signature (if patient is minor)

____ Date:___________