

Performance Chiropractic & Sports Rehabilitation
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Phone (317) 884-0995

PATIENT INFORMATION

Please print and answer the following questions as accurate and complete as possible.

Today's Date: _____

PERSONAL INFORMATION

Name: _____ Age: _____ Sex: M F
(First) (MI) (Last)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Date of Birth: ____/____/____ SS# ____-____-____

Cell Phone: _____ Business/Employer: _____ Work Phone: _____

Email Address: _____ Would you like to receive our E newsletter? Y N

Type of Work Performed: _____ Marital Status: M S W D

Spouse's Name: _____ Children? Sons: _____ Daughters: _____

Emergency Contact: _____ Phone: _____

Who is Your Family Physician? _____ Phone: _____ City: _____

How were you referred to this office? _____ Would you like report sent to Family Physician? Y N

CURRENT HEALTH CONCERNS

Reason for Today's Visit (be specific): _____

When Did This Begin: _____ Experienced Previously? Yes No

Is Condition: Job Related Auto Related Injury Other: _____

Other Doctors Seen For This Problem: _____

Previous Doctor's Opinion/Diagnosis: _____

Were any X-rays/MRIs done: Yes No Where Done: _____

Other or Secondary Complaints: _____

Past Health History

Major Surgeries/Operations: Head Neck/Throat Chest/Heart/Lung
 Back Abdominal Other: _____

Previous Fractures or Broken Bones: Yes No What: _____

Previous Falls or Accidents: Yes No When: _____

Previous Hospitalization: Yes No Why: _____

Previous Chiropractic Care: Yes No Doctor: _____

Medications Now Taking: . . . Pain Killers/Muscle Relaxants Nerve/Anti-depressants
 Blood Pressure Medicine Antibiotics Insulin
 Stomach Medicine Heart Vitamins/Supplements
 Other: _____

Below is a list of diseases and disorders that may seem unrelated to the purpose of your appointment. However, the following information may affect your response to our care as well as our approach to handling your case. Please complete the following as thoroughly as possible.

CHECK ANY OF THE FOLLOWING THAT APPLIES TO YOU:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Osteo-Arthritis | <input type="checkbox"/> Rheumatoid Arthritis | <u>Intake or Use:</u> |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Gout | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> AIDS or ARC | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Frequent Illnesses | <input type="checkbox"/> Lupus | <input type="checkbox"/> Caffeine |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> ALS/MS | <input type="checkbox"/> Drugs of abuse |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Addictions past/present | <input type="checkbox"/> Parkinson's | |

Do you exercise regularly? Yes No Are you dieting? Yes No Since: _____

CHECK ANY PROBLEM AREAS THAT YOU HAVE HAD IN THE PAST YEAR:

Muscles-Skeleton

- Low Back
- Middle Back
- Neck
- Arm(s)
- Leg(s)
- Shoulder(s)
- Knee(s)
- Jaw-TMJ
- General Stiffness

Nerve System

- Headaches
- Nervousness
- Depression
- Numbness/Tingling
- Muscular Weakness
- Dizziness
- Fainting
- Convulsions/Seizures
- Stress
- Shaking/Tremors

Circulation-Breathing

- Chest
- Breathing
- Blood Pressure
- Heart
- Lungs
- Poor Circulation

Digestion-Elimination

- Poor Appetite
- Excessive Thirst
- Nausea
- Diarrhea
- Constipation
- Hemorrhoids
- Weight Loss/Gain
- Gas/Bloating
- Heartburn
- Males Only**
- Prostate Problems
- Testicular Problems
- Erectile Dysfunction

Eye-Ear-Nose-Throat

- Eyes
- Dental
- Throat
- Ear(s)
- Nose
- Sinus

Urinary-Genitals

- Pain Upon Urination
- Infrequent Urination
- Frequent Urination
- Weak Urine Stream
- Bladder Control

Female Only

- Menstrual Problems
- Low Back Pain w/ Periods
- Breast Lumps/Problems
- Are you Pregnant?**
- Yes No Not Sure

FAMILY HISTORY: (i.e., heart, cancer, stroke, diabetes, blood pressure, etc.)

Mother's Side: _____

Father's Side: _____

Any Other Problems Not Listed Above: _____

Signature of Fact, Receipt of Notice of Privacy Policies, Acknowledgement of Insurance Assignment and Release

I understand that Performance Chiropractic may make healthcare and treatment decisions based upon the facts known by the doctor, including the above information, which is true and complete to the best of my knowledge. *I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Performance Chiropractic and Sports Rehabilitation which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice.* I certify that I have insurance coverage and assign directly to Performance Chiropractic all insurance benefits. I agree (1) to pay all charges whether or not paid by insurance, (2) to pay all costs of collection, including reasonable attorney's fees, incurred to enforce this agreement plus those costs incurred to collect a judgment entered against me, and (3) that either Johnson County or Perry Township Small Claims Court, Marion County, shall be the proper forum/venue for any action to collect on a past due account. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient's/Parent's/Legal Guardian's Signature

Date

Office Use Only

- 1
- 4-5
- >5

Patient #: _____

Pain Drawing

Name: _____

Date: _____

Date of Birth: _____

Examiner: _____

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache >>>>>

Burning x x x x

Numbness = = = = =

Stabbing // // // //

Pins & Needles o o o o

Throbbing ~ ~ ~ ~ ~

