Precision Spine Care LLC

NAME: _____AGE: _____DOB: ____/____/_____ DATE:_____

ADDRESS: CITY: STATE: ZIP: _____

PHONE NUMBER FOR TEXT MESSAGE IF AVAILABLE: _____

EMAIL ADDRESS: _____

MALE:_____ FEMALE:_____ HEIGHT: _____WEIGHT:_____ BLOOD PRESSURE:_____

OCCUPATION: EMPLOYER'S NAME AND PHONE #: _____

SINGLE: _____MARRIED: _____SPOUSE'S NAME:_____ DIVORCED:_____ WIDOWED: _____

NO. OF CHILDREN: AGE, GENDER:_____

Addressing what brought you to this office:

Please briefly describe your chief concern, including the effect it has had on your life.

_____

_____

Condition	Severity	Started?	First episode	Related to an injury?	Constant or ermittent mptoms
1					
2					
3					

Please list other Doctors you have seen for this condition: Chiropractor Medical Dr. NUCCA Dr. Other: _____

1. Name/Address_____

Date: _____ What was the diagnosis:_____

2. Name/Address_____

Date: _____ What was the diagnosis:_____

GENERAL HISTORY:

Please check (√) all symptoms you have ever had, even if they do not seem related to your current problem:

	Headaches		Ringing in Ears		Sleep Problems		Urinary Problems
	Pins & Needles In legs		Nervousness		Stiff Neck		Heartburn
	Fainting		Numb fingers		Cold Hands		Menstrual Pain
	Pins & Needles in arms		Loss of taste		Cold Feet		Menstrual Irregularity
	Loss of Smell (sense)		Stomach Upset		Constipation		Ulcers
	Back Pain		Fatigue		Fever		Loss of Balance
	Depression		Hot Flashes		Dizziness		Irritability
	Cold Sweats		Buzzing I Ears		Tension		Light sensitivity in Eyes

Other conditions/diseases you would like the doctor to be informed of:_____

List any medications you are taking and why: (Prescription and non-prescription) _____
_____

Have you had any surgery? (please include all surgical procedures)

1. Type-- Date --Doctor
_____
2 Type-- Date --Doctor
_____
3. Type-- Date --Doctor
_____
4 Type-- Date --Doctor
_____

Accidents and/or injuries: auto, work-related or other (especially those related to your present problems.)

1. Type-- Date --Doctor
_____
2. Type-- Date --Doctor
_____
3. Type-- Date --Doctor
_____

Have you ever had x-rays taken? (if yes) When: _____ Where:_____ Area of body:_____
_____

Do you wear orthotics or heel lifts in your shoes? No Yes What size?_____ For how long?_____

If you've come to the office due to an auto accident or personal injury, please write a paragraph about what happened:

Anything else you would like the Doctor to know:

<u>This form does not need to be signed until you have met with the doctor at your consultation.</u>

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature:_____ Date:_____

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