Welcome to Spees Chiropractic

About You

Date:

Patient Name _____ (Last) _____ (First) _____ (M.I.)

Male ☐ Female ☐ I would prefer to be called: _____

Birthdate _____ Age _____ SS# ___ - ___ - _____

Street Address _____ Apartment _____

City _____ State _____ Zip Code _____

Cell Phone _____ Home Phone _____ Work _____

Email Address _____ Electronic Statement by Email? Yes ☐ No ☐

Occupation _____ Emergency Contact Name &# _____

Employer _____ _____

Employer Address _____

City _____ State _____ Zip Code _____

Status: Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Spouse's Name _____ Spouse Birth Date _____

Spouse's SS# _____ Spouse Phone # _____

Who may we thank for your referral? _____ PCP _____

Have you been to a chiropractor in the past? ☐ Yes ☐ No Name

Your Health History

Date of last:

Physical Exam _____ X-Ray _____

Spinal Exam _____ MRI, CT or Bone Scan _____

Are you taking any of the following medications? ☐ Nerve pills ☐Pain Killers (including aspirin) ☐Muscle relaxers ☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Other (s) _____

Place a mark on "Yes" or "No" to indicate if you've had any of the following:

AIDS/HIV	☐ Yes ☐ No	Fibromyalgia	☐ Yes ☐ No	Parkinsons Disease	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Prostate Issues	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Sexual Dysfunction	☐ Yes ☐ No
Backaches	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Sinus Condition	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Concussion	☐ Yes ☐ No	Menstrual Dysfunction	☐ Yes ☐ No	Thyroid Issues	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Mental Illness	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Digestive Disorder	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Dizziness/Vertigo	☐ Yes ☐ No	Neuritis	☐ Yes ☐ No	Urinary Issues	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Numbness/Tingling	☐ Yes ☐ No	Other	
Epilepsy	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	_____	
Fractures	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	_____	

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Please describe any injuries (work, auto, etc) or surgeries you have had:

_____

Your Concerns

Patient Name:

What are your major complaints or concerns? _____

_____

When and how did your symptoms appear? _____

Are your symptoms ☐getting worse? ☐ getting better?

What treatment have you already received for your condition? ☐ Medications ☐ Surgery

☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other _____

Other doctor(s) that treated you for this condition:

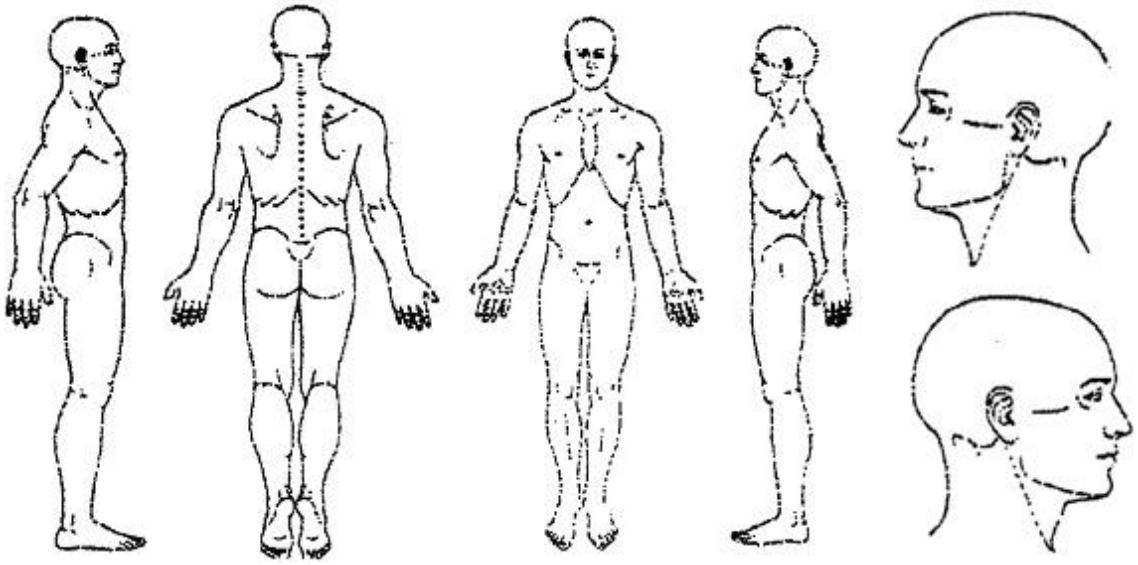
Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain): 1 2 3 4 5 6 7 8 9 10

Type of pain:

☐ **S**harp ☐ **D**ull ☐ **Th**robbing ☐ **A**ching ☐ **Sh**ooting

☐ **B**urning ☐ **N**umbness ☐ **T**ingling ☐ **St**iffness ☐ **O**ther

Place ***MARKS*** on the body to indicate the areas of discomfort



How often do you have this pain? ☐ +75% constant ☐50-75% Frequent ☐25-50% Occasional ☐ <25% Intermit

Does it interfere with: Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐

Activities or movements that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending/Stooping ☐ Lying Down

☐ Looking Up/Down ☐ Turning Head ☐ Driving ☐ Pushing/Pulling ☐ Grooming

☐ Lifting ☐ Reaching ☐ Grasping/Gripping ☐ Squatting/Kneeling ☐ Twisting/Turning

Who else have you seen for this problem? _____

Other comments or concerns regarding your condition:

_____

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understating between provider and patient. I certify that I, and/or my dependent(s), have insurance coverage as stated above and assign directly to Dr. Robert Spees all insurance benefits or legal settlements, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Spees may use my health care information and may disclose such information to my Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits. I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging, and/or other electronic communication to contact me for any reason by using any telephone number, email address, and/or mailing address associated with my account. I understand by signing my name I acknowledge that I have received a copy of the HIPAA guidelines and am in agreement to, and understanding with, its terms and conditions. I acknowledge that I have received a copy of the Informed Consent form and consent to treatment.

Patient Signature _____ Date _____

If patient is under 18:

Guardian Signature _____ Date _____

(Signature above authorizes all treatment to the minor listed on this form.)