Patient Name ______________________________ **Date** ____________________

DATE OF BIRTH: ______________________________ AGE: ____________________

Who referred you to our office? ____

Is this visit a result of:

A Work Injury? **NO** **YES** Date of Injury________________________

An Auto Accident? **NO** **YES** Date of Accident ________________________

Any other type of Injury? **NO** **YES**

If yes, briefly explain ____

Do you have health insurance? ( ) yes ( ) no

Please provide us with your insurance card and a picture ID

Would you like to receive appointment reminder s by text or email? Yes No

Cell #____________________ Carrier: AT&T Cricket Sprint Verizon Other__________________

Please share with us your e-mail address so we may inform you of any important office announcements (ie: office hour changes).

E-mail: ____

Signature: ____

****FOR OFFICE USE ONLY**

_____O _____C _____T _____L _____S _____P ______EXT

Doctor's Comments

____

____

	EXAM	ADJ	TX	X-RAY REF
____ Set up ROF	( ) B2	( ) A1 (1-2 area)	( ) LZ	( ) C
____ Obtain Release	( ) B7 brief	( ) A3 (3-4 area)	( ) P	( ) L
____ Dr.'s Initials	( ) B5 estab	( ) A2 (extremity)		( ) T
		( ) **No Adj**		( ) Other

ROF APPT________________________________ CHARGE________________ _______

Patient Name ______________________________ **Date** ____________________

Address_________________________City______________ State __________ Zip Code __________

H. Phone ____________________W. Phone___________________ Cell Phone ______________________

SS#________________________DOB______________________ Sex: M F Marital Status: M S D W

Email Address ________________________________ Referred by:__________________________

Occupation____

Employer____

Emergency Contact _________________________ Phone________________ Relation_______________

Have you ever received Chiropractic Care? Yes No If yes, when? ____________________________

Name of most recent Chiropractor: ____

1. **Reasons for seeking chiropractic care:**

Primary reason: ____

Secondary reason: ____

2. **Have you been seen by any other doctor for your CURRENT complaint? ( ) NO ( ) YES**

If yes, circle treatment received

Anti-inflammatory Meds	Pain Meds	Muscle Relaxers
Trigger Point Injections	Cortisone Injections	Massage
Physical Therapy	Chiropractic	Other________________

3. **Past Health History:**

   A. **Previous illnesses you've had in your life:**

   ____

   B. **Previous Injury or Trauma:**

   ____

   Have you ever broken any bones? Which?

   ____

   C. **Allergies:** ____

   D. **Medications:**

Medication Reason for taking

____

____

____

____

Patient Name ________________________________ **Date** ________________________

E. **Surgeries:**

Date Type of Surgery

____
____
____

F. **Females/ Pregnancies and outcomes:**

Pregnancies and delivery dates *(live birth/still birth/misc/term)*

____
____
____

4. **Family Health History:**

Associated health problems of relatives:

____
____

Deaths *due to illness* in immediate family: Age at death

____
____

5. **Social and Occupational History:**

A. **Job description:** ____

B. **Work schedule:** ____

C. **Recreational activities:**

____

D. **Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):**

____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Dr. Matthew Robbins** for services performed.

Patient or Guardian Signature ________________________________ Date________________

Patient Name ________________________________ **Date** ____________________

REVIEW OF SYSTEMS

Have you ever been diagnosed with any Pulmonary (Lung) Disorders ☐ **No** ☐ **Yes** (check below)

☐ Asthma/difficulty breathing ☐ COPD ☐ Emphysema ☐ Other_____________

Have you ever been diagnosed with any Cardiovascular (Heart) Disorders ☐ **No** ☐ **Yes** (check below)

☐ Heart surgeries ☐ Congestive heart failure ☐ Murmurs or valvular disease
☐ Heart attacks ☐ Heart disease/problems ☐ hypertension
☐ Pacemaker ☐ Angina/chest pain ☐ Irregular heartbeat
☐ Other_______________

Have you ever been diagnosed with any Neurological (Nerve) Disorders ☐ **No** ☐ **Yes** (check below)

☐ Visual changes/loss of vision ☐ One-sided weakness of face or body
☐ History of seizures ☐ 1-sided decreased feeling in face or body
☐ Headaches ☐ Memory loss
☐ Tremors ☐ Vertigo
☐ Loss of sense of smell ☐ Strokes/TIAs
☐ Other______________________

Have you ever been diagnosed with any Endocrine (Gland) Disorders ☐ **No** ☐ **Yes** (check below)

☐ Thyroid disease ☐ Hormone replacement therapy ☐ Injectable steroid replacements

Have you ever been diagnosed with any Renal (Kidney) Disorders ☐ **No** ☐ **Yes** (check below)

☐ Renal calculi/stones ☐ Hematuria ☐ Incontinence ☐ Bladder infections
☐ Difficulty urinating ☐ Kidney disease ☐ Dialysis ☐ Other_______________

Have you ever been diagnosed with any Gastroenterological (Intestinal) Disorders ☐ **No** ☐ **Yes** (check below)

☐ Nausea ☐ Difficulty swallowing
☐ Ulcerative disease ☐ Frequent abdominal pain
☐ Hiatal hernia ☐ Constipation
☐ Pancreatic disease ☐ Irritable bowel/colitis
☐ Hepatitis or liver disease ☐ Bloody or black tarry stools
☐ Vomiting blood ☐ Bowel incontinence
☐ Gastro esophageal reflux/heartburn ☐ Other____________________

Have you ever been diagnosed with any Hematological (Blood) Disorders ☐ **No** ☐ **Yes** (check below)

☐ Anemia ☐ Regular anti-inflammatory use
☐ HIV positive ☐ Abnormal bleeding/bruising
☐ Sickle-cell anemia ☐ Enlarged lymph nodes
☐ Hemophilia ☐ Hyper coagulation/deep vein thrombosis
☐ Anticoagulant therapy ☐ Regular aspirin use
☐ Other___________________

Have you ever been diagnosed with any Dermatological (Skin) Disorders ☐ **No** ☐ **Yes** (check below)

☐ Significant burns ☐ Significant rashes ☐ Skin grafts ☐ Psoriatic disorders ☐ Other______

Have you ever been diagnosed with any Musculoskeletal (Bone) Disorders ☐ **No** ☐ **Yes** (check below)

☐ Rheumatoid Arthritis ☐ Gout ☐ Osteoarthritis ☐ Broken bones
☐ Spinal fracture ☐ Spinal surgery ☐ Joint surgery ☐ Arthritis (unknown type)
☐ Scoliosis ☐ Metal implants ☐ Other______________

Have you ever been diagnosed with any Psychological (mental) Disorders ☐ **No** ☐ **Yes** (check below)

☐ Psychiatric diagnosis ☐ Depression ☐ Suicidal ideations
☐ Bipolar Disorder ☐ Homicidal ideations ☐ Schizophrenia
☐ Psychiatric hospitalizations ☐ Other__________________