Robbins Chiropractic PC Dr. Matthew D. Robbins

Patient Name_____ **Date**_____

Who referred you to our office? _____

Date of Birth: _____ Age: _____ Sex: M | F Marital Status: M | S | D | W

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Cell #:_____ Carrier: AT&T | Sprint | Verizon | Other _____

Would you like to receive appointment reminders? **TEXT | EMAIL | NO**

Do you have health insurance? **NO | YES** _____

Please provide us with your insurance card and a picture ID

Is this visit a result of:

A Work Injury? **NO | YES** Date of Injury: _____

Auto Accident? **NO | YES** Date of Accident: _____

Other type of Injury? **NO | YES** _____

Are you currently pregnant? **NO | YES** Due Date: _____

_____ **I acknowledge that I have read and understand the adjusting room policy.**
Initial (see laminated copy)

_____

****FOR OFFICE USE ONLY****

Doctor's Comments Previous Chiropractic Care? Yes No When?_____

_____

_____

_____

X-RAY REF

____ Set up Follow Up

____ Obtain Release

____ Dr.'s Initials

( ) NO ADJ

( ) Cervical (4-5 views)

( ) Thoracic (2-3 views)

( ) Lumbosacral (4-5 views)

( ) Other _____

FOLLOW UP APPT:_____CHARGE:_____

1625 W. Ina Rd #117 Tucson, AZ 85704 Phone 520-690-1100 Fax 520-690-1137

Robbins Chiropractic PC Dr. Matthew D. Robbins

Patient Name_____ **Date**_____

Home Phone #: _____ Work Phone #: _____
Occupation:_____ Employer: _____
Emergency Contact Required: _____ Phone: _____ Relation: _____
Have you received any other treatment for your injuries from *this accident*? **NO** | **YES**
If YES, circle treatment(s) received:

Anti-inflammatory Meds	Pain Meds	Surgery	Other _____
Cortisone Injections	Massage	Trigger Point Injections	
Chiropractic	Muscle Relaxers	Physical Therapy	

Family History - Place an X in all applicable boxes

Condition	Mother	Father	Sibling	Grandmother		Grandfather		Notes
				Maternal	Paternal	Maternal	Paternal	
Cancer								
High Blood Pressure								
Heart Attack								
Diabetes								
Stroke								
Osteoarthritis								
Other								

Females: Are you pregnant? **Yes** **No** Due date_____

Past Health History:

Previous Injury/Trauma: _____

Have you ever broken any bones? Which? _____

Medications:

Medication + reason for taking

_____

Surgeries:

Surgery - exact date (best guess)

_____

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 is billed, I authorize payment of medical benefits to **Dr. Matthew Robbins** for services performed.

Patient or Guardian Signature _____ Date_____

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Patient Name_____ **Date**_____

REVIEW OF SYSTEMS

ALLERGIES/IMMUNOLOGIC HISTORY

☐ **ALL NEVER**

Allergic Reactions	____Current	____Past	____Never	HIV Positive	____Current	____Past	____Never
Anaphylaxis History	____Current	____Past	____Never	Positive Tuberculosis	____Current	____Past	____Never
Angioedema History	____Current	____Past	____Never	Seasonal Allergies	____Current	____Past	____Never
Drug Allergies	____Current	____Past	____Never	COVID	____Current	____Past	____Never
Frequent Injections	____Current	____Past	____Never	Rheumatoid Arthritis	____Current	____Past	____Never
Hay Fever	____Current	____Past	____Never	Psoriatic Arthritis	____Current	____Past	____Never
Hepatitis	____Current	____Past	____Never	Osteoarthritis	____Current	____Past	____Never

Cardiovascular History

☐ **ALL NEVER**

Chest Pain	____Current	____Past	____Never
Heart Murmur	____Current	____Past	____Never
High Blood Pressure	____Current	____Past	____Never
Irregular Heartbeat	____Current	____Past	____Never
Swelling of Legs	____Current	____Past	____Never
Use of Oxygen	____Current	____Past	____Never
Varicose Veins	____Current	____Past	____Never
Other_____	____Current	____Past	____Never

Gastrointestinal History

☐ **ALL NEVER**

Abdominal Pain	____Current	____Past	____Never
Constipation	____Current	____Past	____Never
Diarrhea	____Current	____Past	____Never
Gluten Intolerance	____Current	____Past	____Never
Indigestion/Heartburn	____Current	____Past	____Never
Nausea	____Current	____Past	____Never
Crohn's Disease	____Current	____Past	____Never
Ulcerative Colitis	____Current	____Past	____Never
Other_____	____Current	____Past	____Never

Musculoskeletal History

☐ **ALL NEVER**

Joint Pain	____Current	____Past	____Never
Walking/Balance Problems	____Current	____Past	____Never
Osteoporosis	____Current	____Past	____Never
Ehlers-Danlos Syndrome	____Current	____Past	____Never
Hypermobility	____Current	____Past	____Never
Osteopenia	____Current	____Past	____Never
Joint Replacement	____Current	____Past	____Never
Spinal Fusion	____Current	____Past	____Never
Disc Replacement	____Current	____Past	____Never
Other_____	____Current	____Past	____Never

Psychiatric History

☐ **ALL NEVER**

Depression	____Current	____Past	____Never
Memory/Forgetfulness	____Current	____Past	____Never
Other_____	____Current	____Past	____Never

Endocrinological History

☐ **ALL NEVER**

Diabetes Type I	____Current	____Past	____Never
Diabetes Type II	____Current	____Past	____Never
Hypoglycemia	____Current	____Past	____Never
Thyroid	____Current	____Past	____Never

Hematologic/Lymphatic History

☐ **ALL NEVER**

Anemia	____Current	____Past	____Never
Blood Clotting Problems	____Current	____Past	____Never
Easy Bruising/Bleeding	____Current	____Past	____Never
Enlarged Lymph Nodes	____Current	____Past	____Never
Swollen Glands	____Current	____Past	____Never
PVD	____Current	____Past	____Never
AbdominalAortic Aneurysm	____Current	____Past	____Never
Deep Vein Thrombosis	____Current	____Past	____Never
Cancer	____Current	____Past	____Never
Hemophilia	____Current	____Past	____Never
Other_____	____Current	____Past	____Never

Neurological History

☐ **ALL NEVER**

Dizzy Spells	____Current	____Past	____Never
Headaches	____Current	____Past	____Never
Loss of Balance	____Current	____Past	____Never
Migraines	____Current	____Past	____Never
Numbness/Tingling	____Current	____Past	____Never
Tremors	____Current	____Past	____Never
Ringing in Ears	____Current	____Past	____Never
Seizures	____Current	____Past	____Never
Slurred Speech	____Current	____Past	____Never
Stroke	____Current	____Past	____Never
Other_____	____Current	____Past	____Never

Respiratory History

☐ **ALL NEVER**

Blood in Sputum	____Current	____Past	____Never
Frequent Cough	____Current	____Past	____Never
Shortness of Breath	____Current	____Past	____Never
Wheezing	____Current	____Past	____Never
Other_____	____Current	____Past	____Never