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.** (see laminated copy)
Initial

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

Doctor's Comments

_____

_____

_____

X-RAY REF

____ Set up Follow Up
____ Obtain Release
____ Dr.'s Initials

( ) NO ADJ

( ) Cervical (2-3 views)
( ) Thoracic (2-3 views)
( ) Lumbosacral (2-3 views)
( ) Other _____

FOLLOW UP APPT:_____CHARGE:_____

NAME _____ **Date** _____

Home Phone #: _____ Work Phone #: _____ SS#: _____
Occupation:_____ Employer: _____
Emergency Contact: _____ Phone: _____ Relation: _____
Reason(s) for seeking Chiropractic care: _____

Have you ever received Chiropractic Care? **NO** | **YES** - When? _____
Name of most recent Chiropractor: _____
Have you been seen by any other doctor for your CURRENT complaint? **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	

Past Health History:
Previous Illnesses: _____
Previous Injury/Trauma: _____
Have you ever broken any bones? Which? _____
Allergies: _____

Medications:
Medication + reason for taking

_____
_____
_____

Surgeries:
Surgery + date

_____
_____

Family Health History:
Associated health problems of relatives

_____
_____

Level of Physical Activity
Exercise, sports, etc.

_____

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_____

1625 W. Ina Road Ste 117 **Tucson, AZ 85704**
Phone 520-690-1100 **www.robbinschiropractic.com** **Fax 520-690-1137**

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 Oncological (Tumors) Disorders ☐ **No** ☐ **Yes** (check below)
☐ Fevers/chills/sweats/ unexplained weight loss ☐ Abnormal bleeding/bruising ☐ Current/past oncology disease _____

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_____