Robbins Chiropractic Center

Dr. Matthew D. Robbins

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 by text or email? Yes No

Cell # _____ Carrier: AT&T Sprint Verizon Cricket 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	( ) C2 Cerv (AP, APOM,LAT)	( ) C
____ Obtain Release	( ) B7 brief	( ) A3 (3-4 area)	( ) P	( ) C6 Lumb (AP & LAT)	( ) L
____ Dr.'s Initials	( ) B5 estab	( ) A2 (extremity)		( ) C5 Thor (AP & LAT)	( ) Other
		( ) **No Adj**		( ) Other_____	_____

ROF APPT _____ CHARGE _____ _____

194 W. Fort Lowell Rd.
Phone 520-690-1100

www.robbinschiropractic.com

Tucson, AZ 85705
Fax 520-690-1137

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

Emergency Contact _____ Phone_____ Relation_____

Referred by: _____

Occupation_____

Employer_____

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

_____
_____

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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_____