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.** (see laminated copy)
Initial

****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: ____________

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**

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

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

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

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
- ☐ Difficulty urinating
- ☐ Hematuria
- ☐ Kidney disease
- ☐ Incontinence
- ☐ Dialysis
- ☐ Bladder infections
- ☐ Other_______________

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

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

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

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

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

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

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