CREIGHTON CHIROPRACTIC CENTER

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1.PATIENT INFORMATION

NAME: _____ DOB: _____ SEX: Male / Female SOCIAL SECURITY: _____

PRIMARY PHONE: _____ CELL PROVIDER : _____ EMAIL: _____ MARITAL STATUS_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYER NAME AND ADDRESS: _____ WORK PHONE: _____

EMERGENCY CONTACT: _____ NUMBER: _____ RELATION TO YOU: _____

2.PATIENT HEALTH HISTORY

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST:

AIDS/HIV	COPD	HERPES	PNEUMONIA
ALCOHOLISOM	DIABETES	HIGH CHOLESTEROL	POLIO
ANEMIA	EMPHYSEMA	INSOMNIA	PROSTATE PROBLEMS
ANOREXIA	EPILEPSY	KIDNEY DISEASE	PROTHESIS
APPENDICITIS	FRACTURES	LIVER DISEASE	PSYCHIATRIC CARE
ARTHRITIS	GLAUCOMA	MEASLES	RHEUMATOID ARTHRITIS
ASTHMA	GOITER	MIGRAINES	RHEUMATIC FEVER
BLEEDING DISORDER	GONORRHEA	MONONUCLEOSIS	FATIGUE
BRONCHITIS	GOUT	MULTIPLE SCLEROSIS	FIBROMYALGIA
BULIMIA	HEADACHES	MUMPS	
CANCER	HEART DISEASE	OSTEOPOROSIS	
CATARACTS	HEPATITIS	PACEMAKER	
CHEMICAL DEPENDANCY	HERNIA	PARKINSON'S DISEASE	
CHICKEN POX	HERNIATED DISK	PINCHED NERVE	

PLEASE INDICATE IF HAVE YOU SUFFERED WITH ANY PROBLEMS IN THE FOLLOWING AREAS:

GENERAL WELLBEING LOSS OF SLEEP WEIGHT GAIN/LOSS FEVER	**MOUTH/THROAT** SORES ENLARGED GLANDS BLEEDING
SKIN RASH ECZEMA BRUISING	**EARS** DISCHARGE PAIN RINGING
NEUROLOGIC DIZZINESS NERVOUSNESS CONVULSIONS	**PSYCHOLOGIC** ANXIETY DEPRESSION MOOD SWINGS
EYES PAIN DISCHARGE VISION DIFFICULTIES NORMAL	**NOSE** INFECTIONS BLEEDING SINUS PROBLEMS PAIN
HEART/LUNGS COUGH MURMUR VARICOSITIES CHEST PAIN	**GENITOURINARY** PROSTATE PROBLEMS PAINFUL MENSTRATION IRREGULARITY NIGHT SWEATS
STOMACH/DIGESTION DIARRHEA EXCESS GAS HEMORRHOIDS	**ENDOCRINE/METABOLISM** GOITOR TREMOR INFECTION

3. PATIENT CONDITION

What are your primary complaints? NONE (OR) PLEASE CIRCLE THE SYMPTOMS YOU ARE SUFFERING WITH:

LEFT SIDE	Pain	Soreness	Tingling	Stiffness	Numbness	Swelling	Weakness		*RIGHT SIDE*	Pain	Soreness	Tingling	Stiffness	Numbness	Swelling	Weakness
	P	S	T	S	N	S	W	HEAD		P	S	T	S	N	S	W
	P	S	T	S	N	S	W	NECK		P	S	T	S	N	S	W
	P	S	T	S	N	S	W	UPPER BACK		P	S	T	S	N	S	W
	P	S	T	S	N	S	W	MID BACK		P	S	T	S	N	S	W
	P	S	T	S	N	S	W	LOWER BACK		P	S	T	S	N	S	W
	P	S	T	S	N	S	W	SHOULDERS		P	S	T	S	N	S	W
	P	S	T	S	N	S	W	ARMS		P	S	T	S	N	S	W
	P	S	T	S	N	S	W	FOREARMS		P	S	T	S	N	S	W
	P	S	T	S	N	S	W	WRIST		P	S	T	S	N	S	W
	P	S	T	S	N	S	W	HANDS		P	S	T	S	N	S	W
	P	S	T	S	N	S	W	RIBS		P	S	T	S	N	S	W
	P	S	T	S	N	S	W	BUTTOCKS		P	S	T	S	N	S	W
	P	S	T	S	N	S	W	HIP		P	S	T	S	N	S	W
	P	S	T	S	N	S	W	THIGHS		P	S	T	S	N	S	W
	P	S	T	S	N	S	W	LEGS		P	S	T	S	N	S	W
	P	S	T	S	N	S	W	KNEES		P	S	T	S	N	S	W
	P	S	T	S	N	S	W	ANKLES		P	S	T	S	N	S	W
	P	S	T	S	N	S	W	FEET		P	S	T	S	N	S	W

1. How would you rate your OVERALL PAIN today with "0" being NO PAIN and "10" being THE WORST PAIN: _____

2. Is the PAIN: ☐ Constant ☐ Almost Constant ☐Off & On ☐ Occasional ☐Other_____

3. When did the PAIN begin?_____ Since, have your symptoms: ☐Decreased ☐Increased ☐Stayed the Same

4. Is the pain aggravated by: ☐Coughing ☐Sneezing ☐Straining at Stool ☐Reaching ☐Lifting ☐Bending ☐Standing ☐Sitting ☐Neck Movement ☐Walking ☐Other:_____

5. Is the pain RELIEVED by: ☐Rest ☐Exercise ☐Stretching ☐Heat/Ice ☐Sitting ☐Standing ☐Nothing ☐Other:_____

6. Does it interfere with your: ☐ Work ☐Sleep ☐Daily Routine ☐Recreation

7. What treatment have you already received for your condition: ☐Medications ☐Surgery ☐Physical Therapy ☐Chiropractic Services ☐ None ☐Other:_____

Name & Number of Doctor:_____

8. Has this condition existed in the past ☐Yes ☐NO, If yes please tell us the date:_____

9. Since your symptoms began, have you noticed a change in your: ☐Bowel Function ☐Bladder Function ☐Sexual Function
Clarify:_____

10. Are you Pregnant: ☐UNSURE ☐YES ☐NO, Due Date:_____OR Last Menstrual Period:_____

11. Do you have a family physician? ☐YES ☐NO, If YES, HIS/HER NAME & PHONE NUMBER:_____
_____Date of Last Visit_____

12. List ALL KNOWN Allergies:_____

PLEASE LIST ALL MEDICATIONS, VITAMINS, HERBS AND MINERALS YOU ARE TAKING

NAME	DOSAGE AND FREQUENCY	REASON

4. PATIENT DAILY ACTIVITIES

What are your daily exercise habits: ☐None ☐Moderate ☐Daily ☐Heavy

Do your work duties consist of: ☐Sitting ☐Standing ☐Light Labor ☐Heavy Labor

DO YOU SMOKE	☐YES ☐NO	PACKS PER DAY:
DRINK ALCOHOL	☐YES ☐NO	DRINKS PER DAY / WEEK:
DRINK COFFEE/ SODA	☐YES ☐NO	DRINKS PER DAY / WEEK:
HIGH STRESS LEVEL	☐YES ☐NO	REASON:

5. PAST SIGNICANT HISTORY

HAVE YOU SUFFERED ANY OF THE FOLLOWING:		DATE(S)	DESCRIPTION(S)
FALLS	☐YES ☐NO		
HEAD INJURIES	☐YES ☐NO		
DISLOCATIONS	☐YES ☐NO		
ACCIDENT	☐WORK ☐AUTO		
2nd ACCIDENT	☐WORK ☐AUTO		
3rd ACCIDENT	☐WORK ☐AUTO		
SURGERIES/HOSPITILIZATIONS	☐YES ☐NO		
2nd			
3rd			

6. INSURANCE / BILLING INFORMATION

Who is responsible for this account?_____ Relationship to Patient:_____

A. If you have MEDICAL INSURANCE, please supply us with the following information:

Subscriber's Name:_____ Date of Birth:_____ Social Security#:_____

Employer Name:_____ Insurance Company Name:_____

B. If you have SECONDARY MEDICAL INSURANCE, please supply us with the following information:

Subscriber's Name:_____ Date of Birth:_____ Social Security#:_____

Employer Name:_____ Insurance Company Name:_____

Are you being seen today due to injuries sustained in a recent automobile accident? ☐YES ☐NO, If NO SKIP SECTION 7.

PLEASE NOTE: ONLY COMPLETE THE FOLLOWING IF YOU ARE HERE DUE TO INJURIES SUSTAINED IN A MOTOR VEHICLE ACCIDENT.

7. AUTO ACCIDENT HISTORY

1. You were the: ☐Driver ☐Front Seat Passenger ☐In the Rear Seat (☐Right ☐Middle ☐Left) Other:_____
2. Year, Make and Model of the Vehicle you were in:_____
3. Other vehicle involved in the accident was a: ☐Compact ☐Mid Size ☐Full Size ☐Van ☐Truck ☐Other:_____
4. How did this vehicle strike the vehicle you were in? ☐Head On ☐Right ☐Left ☐Rear ☐Other:_____
5. What was your estimated speed at the moment of the accident? _____mph, ☐Stopped ☐Slowing ☐Accelerating
6. Time of day was: ☐Daylight ☐Dawn ☐Dusk ☐Night, & Road Conditions were: ☐Dry ☐Wet ☐Damp ☐Other:_____
7. Visibility at the time of impact was: ☐Good ☐Fair ☐Poor, If POOR, why? ☐Sun ☐Dark ☐Rain ☐Fog ☐Other:_____
8. What type of seat belt were you wearing? ☐None ☐Lap ☐Shoulder ☐Lap & Shoulder, Did it malfunction? ☐YES ☐NO
9. Did the air bag deploy? ☐YES ☐NO, Did it strike you? ☐YES ☐NO If YES, where:_____
10. Did the seat you were in, have a head restraint? ☐Unsure ☐None ☐Yes, Adjusted ☐UP ☐DOWN
11. Was the position of your seat adjusted, altered or broken during the crash? ☐YES ☐NO, Explain:_____
12. How was your BODY positioned before the impact? ☐Slouched ☐Straight (☐Leaning ☐LEFT ☐RIGHT)☐Other:_____
13. How was your HEAD positioned before the impact? ☐Forward ☐Right ☐Left ☐Up ☐Down ☐Other:_____

14. Was your BODY thrown during the accident? ☐YES ☐NO, If YES, how? ☐ Outside Vehicle ☐ Under Vehicle ☐ Sideways ☐ Forwards/ Backwards ☐Backwards/Forwards ☐ Across Vehicle ☐ Don't Recall ☐ Other:_____

15. Were BOTH of your HANDS on the steering wheel? ☐YES ☐NO ☐Don't Recall, If No, ☐Left Only ☐Right Only

16. Did the CRASH take you by: ☐ Complete Surprise or were you able to ☐ Brace for the Impending Collision

17. Did your body strike the interior of the vehicle? ☐YES ☐NO If YES, where & were you injured:_____

_____

18. Did your vehicle strike any other objects after the crash? Explain:_____

19. Were you wearing a hat or glasses? ☐YES ☐NO If yes, were they thrown off during the crash? ☐YES ☐NO

20. Did you lose consciousness? ☐YES ☐NO, If YES, for how long?_____

21. Did the police arrive at the scene of the accident? ☐YES ☐NO Who was issued the traffic citation:_____

22. What was the ESTIMATED damage to YOUR vehicle: $_____, Other Vehicle $_____

23. Did the ambulance arrive at the scene of the accident? ☐YES ☐NO, Was care rendered to you? ☐YES ☐NO

24. Did they transport you to a hospital? ☐YES ☐NO, If YES, where:_____

What body part(s) were X-RAY's taken on?_____Results?_____

What prescription and diagnosis was given?_____

If NO, were did you go after the accident? _____Whom drove you?_____

25. Where did you <u>immediately develop PAIN</u>? ☐Head ☐Neck ☐Upper/Mid Back ☐Low Back ☐Pelvis ☐Chest/Rib Cage ☐Abdomen ☐Shoulders ☐Arms/Elbows ☐Wrists/Hands ☐Hips ☐Knees/Legs ☐Ankles/Feet ☐Other_____

26. <u>Later</u>, did you develop pain elsewhere? ☐YES ☐NO, If YES, when and on what body part:_____

_____

27. Please describe any lacerations or significant injuries:_____

28. Have you experienced any of the following since the accident? ☐Anxiety ☐Depression ☐Mood Swings ☐Nervousness ☐Poor Memory ☐Tension ☐Convulsions ☐Dizziness ☐Headaches ☐Fainting ☐Loss of Balance ☐Fatigue ☐Insomnia ☐Restlessness ☐Light Sensitivity ☐Reduced Appetite ☐Weakness ☐Weight Gain ☐Weight Loss ☐Other:_____

29. Are you restricted in any of the following areas as a result of the accident/injury? ☐Daily Living ☐Work Duties ☐Recreational Activities ☐Other, explain:_____

30. Have you missed work or been placed on limited work activity due to injuries sustained in this accident? ☐YES ☐NO If YES, Missed Work FROM:____/____/____ TO:____/____/____REASON:_____

31. Date of Auto Accident:_____ Time:_____ Reported to your Auto Insurance Company? ☐YES ☐NO

32. Are you being represented by an ATTORNEY in this matter? ☐YES ☐NO, If YES, please provide His/Her NAME and PHONE NUMBER:_____

8. ACKNOWLEDGEMENT

I certify that I completed the above information accurately and thoroughly to the best of my ability. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them, or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Print Patient Name:_____ Signature:_____ Date:_____

IF PATIENT IS A MINOR CHILD, PARENT MUST ALSO COMPLETE THE FOLLOWING:

The patient_____is a minor child, _____, years of age. I, _____, guardian of the minor child, authorize the performance of diagnostic x-rays, examination and chiropractic treatment of my child or ward which Dr. Maria R. Sangillo may consider necessary or advisable in the course of examination and treatment.

Guardian Signature:_____Relationship to Child: _____Date:_____

Notary Signature:_____ Date:_____