PEAK
CHIROPRACTIC
AND FUNCTIONAL WELLNESS

Confidential Patient Information

Date:_____ / _____ / _____

Patient's Full Name _____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ E-Mail: _____

☐ Male ☐ Female Date of Birth:_____/____/_____ ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Spouse's Name:_____ Number of Children/Ages_____

How did you find us?

☐ Existing Patient
Name:_____
☐ Physician
Name:_____
☐ Friend
Name:_____

☐ Office Website
☐ Other Website:_____
☐ Other _____

☐ Google:_____
☐ Social Media (i.e. Facebook)

Social Security # _____ - _____ - _____

Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Unemployed Occupation:_____

Employer:_____ Employer Address:_____ Business Phone_____

Emergency Contact:_____ Relationship:_____ Phone: _____-_____-_____

Family Physician: _____ City: _____ State:_____ Phone_____

Previous Chiropractic Care: ☐ Yes ☐ No If Yes, for what Problem: _____

Clinic/Doctor's Name _____ City: _____ State: _____

Is Today's Visit Due To A Work Related Injury: ☐ Yes ☐ No **Is Today's Visit Due To An Auto Accident:** ☐ Yes ☐ No
(If yes to either questions above, please check with receptionist, additional information is needed)
Date of Injury:_____

Authorization and Assignment

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, **I personally owe to you**.
4. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you (Peak Chiropractic, PLLC) are **paid in full**.

Patient Signature:_____ **Date:**_____/_____/_____

Confidential Patient Information

Symptom Survey

Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Present complaint(s):_____

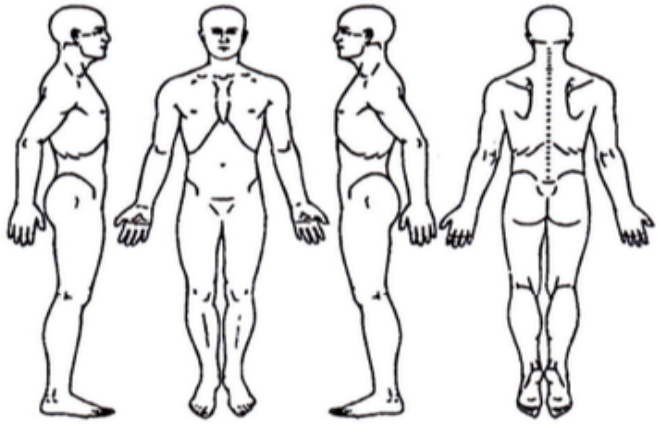
When did your symptoms begin? (Specific date if possible)_____

How did your symptoms begin? (i.e. Lifting, ect.)_____

In the past have you had anything similar to this? ☐ Yes ☐ No Please explain_____

PAIN CHART

Please use the diagram to the right to mark the areas you are experiencing pain



DESCRIBE YOUR PAIN

#1 Complaint _____

(Rate your level of Pain, Scale 0-10)

0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

Check all that apply to your #1 Complaint

☐ Sharp	☐ Ache	☐ Tingling
☐ Stabbing	☐ Soreness	☐ Numbness
☐ Burning	☐ Weakness	☐ Dull
☐ Shooting	☐ Throbbing	☐ Constricting

☐ Other_____

How often are your complaints present?
☐ Constant (100%) ☐ Frequently (75%)
☐ Intermittent (50%) ☐ Occasional (25%)

DESCRIBE YOUR PAIN

#2 Complaint _____

(Rate your level of Pain, Scale 0-10)

0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

Check all that apply to your #1 Complaint

☐ Sharp	☐ Ache	☐ Tingling
☐ Stabbing	☐ Soreness	☐ Numbness
☐ Burning	☐ Weakness	☐ Dull
☐ Shooting	☐ Throbbing	☐ Constricting

☐ Other_____

How often are your complaints present?
☐ Constant (100%) ☐ Frequently (75%)
☐ Intermittent (50%) ☐ Occasional (25%)

DESCRIBE YOUR PAIN

#3 Complaint _____

(Rate your level of Pain, Scale 0-10)

0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

Check all that apply to your #1 Complaint

☐ Sharp	☐ Ache	☐ Tingling
☐ Stabbing	☐ Soreness	☐ Numbness
☐ Burning	☐ Weakness	☐ Dull
☐ Shooting	☐ Throbbing	☐ Constricting

☐ Other_____

How often are your complaints present?
☐ Constant (100%) ☐ Frequently (75%)
☐ Intermittent (50%) ☐ Occasional (25%)

Is your Pain:
☐ Increasing
☐ Decreasing
☐ Not Changing
☐ Varies

Was the Onset:
☐ Gradual
☐ Sudden

Pain is aggravated by:
☐ Walking ☐ Lifting
☐ Sitting ☐ Bending
☐ Riding in a car ☐ Stretching
☐ Standing ☐ Twisting
☐ Other_____

Pain is relieved by:
☐ Medication ☐ Chiropractic Adjustments
☐ Rest ☐ Cold
☐ Exercise ☐ Heat
☐ Therapy
☐ Other_____

Confidential Patient Information

Questionnaire

☐ Yes ☐ No Is it okay to inform your PCP? If Yes please specify name and address_____

☐ Yes ☐ No Is pain affecting your ability to work or be active? If Yes explain:_____

☐ Yes ☐ No Any change in bowel or bladder (bathroom) function? If Yes explain:_____

☐ Yes ☐ No Any fever or chills? If Yes explain:_____

☐ Yes ☐ No Any dizziness associated with symptoms? If Yes explain:_____

☐ Yes ☐ No Have you experienced any unexplained weight loss, fatigue, or blood loss? If Yes explain:_____

☐ Yes ☐ No Are your complaints affecting your sleep? If Yes explain:_____

☐ Yes ☐ No Have you had any tests for this complaint? (i.e. x-rays, MRI, CT) If Yes explain:_____

☐ Yes ☐ No Any recent falls / accidents / surgeries / broken bones? If Yes explain:_____

☐ Yes ☐ No Have you seen any other physicians in the past 6 months? If Yes explain:_____

☐ Yes ☐ No Have you had any prior treatment, including any physical therapy? If Yes, who?_____

What treatment?_____

☐ Yes ☐ No Have you been in the hospital or had surgery for any reason? If Yes explain:_____

☐ Yes ☐ No Have you ever been in an accident? If Yes explain:_____

What **non-prescription** medication are you taking?

☐ Tylenol ☐ Aspirin
☐ Ibuprofen ☐ None
☐ Other_____

How often?
☐Daily ☐Weekly ☐Other:_____

What **Prescription** medication are you taking?

☐ Anti-inflammatory ☐ Birth Control Pill ☐ Diet Pills
☐ Pain Killers ☐ Cholesterol Meds ☐ Nerve Pills
☐ Muscle Relaxers ☐ Insulin ☐ HRT
☐ Blood Pressure Meds ☐ Tranquilizers ☐ Sleeping Aid
☐ Other_____ ☐ None
Specific names if possible:_____

☐ Yes ☐ No Do you smoke? If Yes how much?:_____

If you have quit smoking, when did you quit?_____

☐ Yes ☐ No Do you consume alcohol?

☐ Yes ☐ No Do you exercise? If Yes what is your routine?_____

What type of care are you interested in: ☐ Pain relief only ☐ Healing of current condition ☐ Optimizing your health ☐ All three

FAMILY HISTORY AND HEALTH STATUS: list any diseases, disorders, or major illnesses. If deceased, from what?

Mother:_____ Father:_____

Brother(s):_____ Sister(s):_____

Other:_____ Other:_____

Other health concerns?_____