Saks Wellness Center PC

CONFIDENTIAL PATIENT DATA

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE FRONT DESK

Today's date:			
PATIENT INFORMATION			
Patient's name: (Last, First, Middle Initial)	S.S. #:	Date of Birth:	Sex: ❑M ❑F
Mailing address:	Home Phone:	Primary Phone: ❑Home ❑Work ❑Cell	
Mailing address Line 2:	Cell Phone:		
City:	State:	Zip Code:	Email:
Occupation:	Employer:		
Work Phone:	May we contact you at work? ❑Yes ❑No		
Work Activities: ❑Sit ❑Stand ❑Walk ❑Light Labor ❑Heavy Labor			
Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated ❑Decline to answer	Spouse's Name:		
Children: ❑Yes ❑No If yes, how many?	Spouse's Date of Birth:		
Would you like to receive appointment reminders? Choose ONE: ❑Email ❑Text Message ❑Phone Call ❑None			
Preferred Language: ❑English ❑Spanish ❑Other _____	Ethnicity: ❑Hispanic or Latino ❑Non-Hispanic or non-Latino ❑Declined to Answer		
Please check ALL races that apply: ❑White ❑Black or African American ❑American Indian or Alaska Native ❑Asian ❑Native Hawaiian/Pacific Islander ❑Decline to Answer			
Have you ever consulted a chiropractor before? ❑No ❑Yes; whom?	Whom may we thank for referring you?		
Alcohol Use: ❑None ❑Light ❑Moderate ❑Heavy	**Drug Use:** ❑None ❑Light ❑Moderate ❑Heavy	**Exercise:** ❑None ❑Daily ❑Weekly ❑Monthly ❑Rarely	
Smoking Status: ❑Current everyday ❑Current some days ❑Former ❑Never Start Year _____ Quit Date _____			
Typical eating habits: ❑Skip breakfast ❑Two meals a day ❑Three meals a day ❑Snacking between meals			
Medications:	**Supplements:**	**Allergies:**	

INSURANCE INFORMATION	
Primary Insurance:	Insured ID:

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

Primary Care Physician	
Name (First and Last):	
Phone Number:	
Date of Last Appointment:	

ARE YOU INTERESTED IN ANY OF THE FOLLOWING SERVICES WE OFFER?		
Service	**YES**	**NO**
Chiropractic Care		
Nutritional Therapy		
Massage Therapy		
Rehabilitation/Exercise Therapy		

Release of Medical Information and Emergency Contact:

Please list ALL persons we may share your medical/health information with or contact if we cannot reach you. An *emergency contact* is the first person medical personnel will get in touch with in the case of an emergency.

Name (First and Last)	Phone Number
1. **Emergency Contact*	
2.	
3.	

I verify the above and previous information listed regarding my health history is current and accurate.

X_____Date:_____/_____/_____

FOR OFFICE USE ONLY		
HEIGHT:	WEIGHT:	BP:

HEALTH HISTORY

In general, how would you rate your overall health? ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

Review of Systems: Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please check the box beside any condition that you've had or currently have.

☐Acne	☐Cancer	☐Heart burn	☐Loss of Smell or Taste	☐Prostate Issues
☐Alcoholism	☐Carpal Tunnel	☐High Blood Pressure	☐Liver Disease	☐Prosthesis
☐Allergies	☐Chicken Pox	☐High Cholesterol	☐Migraine	☐Psoriasis
☐Anemia	☐Constipation	☐Glaucoma	☐Menopause	☐Rheumatism
☐Angina	☐Diabetes	☐Goiter	☐Mono	☐Rheumatic Fever
☐Anorexia or Bulimia	☐Dementia	☐Hair Loss	☐Multiple Sclerosis	☐Ringing in Ears
☐Anxiety	☐Depression	☐Headache	☐Mental Disease	☐Scoliosis
☐Appendicitis	☐Diarrhea	☐Hernia	☐Mumps	☐Shortness of Breath
☐Asthma	☐Earache	☐Herniated Disc	☐Neck/Back Pain	☐Shoulder Problems
☐Arthritis	☐Eczema	☐Hip Disorder	☐Numbness	☐Sleep apnea
☐Alzheimer's	☐Emphysema	☐Hypoglycemia	☐Osteoporosis	☐STD
☐AIDS	☐Excessive Bruising	☐Impotency	☐Pacemaker	☐Sudden Weight Loss/Gain
☐Bed Wetting	☐Fainting	☐Infertility	☐ PCOS	☐Suicide Attempt
☐Bleeding Disorder	☐Fibromyalgia	☐Irregular Heart	☐Pinched Nerve	☐Thyroid Disorder
☐Blurred Vision	☐Frequent Infections	☐Kidney Disease	☐ "Pins and Needles"	☐Tonsillitis
☐Breast Lump	☐Food Sensitivities	☐Kidney Stones	☐Poor Posture	☐TMJ Issues
☐Broken Bone	☐Foot/Ankle Problems	☐Knee Injury	☐Poor Circulation	☐OTHER:_____
☐Bronchitis	☐Hearing Loss	☐Low Blood Pressure	☐Pneumonia	_____
☐Blood Clots	☐Heart Disease		☐Polio	

PATIENT HISTORY

Please describe your past surgeries:

☐Spine:_____

☐Other: _____ ☐None

Please describe your past accidents:

1. Accident:_____(Date):_____☐Job ☐Auto ☐Other
2. Accident:_____(Date):_____☐Job ☐Auto ☐Other
3. Accident:_____(Date):_____☐Job ☐Auto ☐Other

FAMILY HISTORY

☐Arthritis	☐Cancer	☐Headache	☐Liver Disease	☐Migraine	☐Thyroid Disorder
☐Asthma	☐Diabetes	☐Heart Disease	☐Low Blood Pressure	☐Osteoporosis	☐TMJ Issues
☐Alzheimer's	☐Dementia	☐High Blood Pressure	☐Lung Disease	☐Rheumatism	☐OTHER:
☐Autoimmune disease	☐Depression	☐High Cholesterol	☐Mental Disease	☐Scoliosis	
☐Blood Clots	☐Fibromyalgia	☐Kidney Disease	☐Multiple Sclerosis	☐Stroke	

I verify the above and previous information listed regarding my health history is current and accurate.

X_____Date:_____/_____/_____

Saks Wellness Center PC

NAME:_____

D.O.B:_____ DATE:_____

Write your WORST symptom or area of irritation on this page

Please fill out the form below to describe your current symptoms.

SYMPTOM 1

Symptom:

Area of irritation:_____ **Doctor's notes:**_____

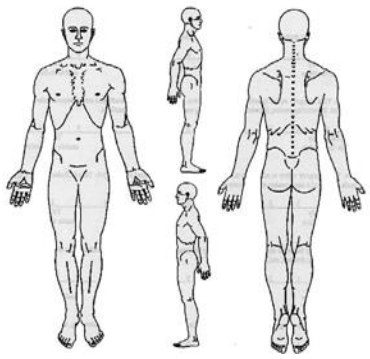
Pain rating (1-10, with 10 being worst imaginable):
❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Main impaired activity made more difficult by above symptom:

Pain Quality:	**Pain Frequency:**	**Pain Radiates Into:**	**Pain Cause:**	**Pain Duration:**
❑Aching ❑Burning ❑Cramping ❑Numbness ❑Sharp ❑Shooting ❑Stiffness ❑Tingling	❑Constant ❑Frequent ❑Intermittent ❑Occasional	❑Arm ❑Leg ❑Shoulder ❑Buttock ***And*** ❑Right Side ❑Left Side ❑Both Sides	❑A Fall ❑Auto Accident ❑Lifting Injury ❑Unknown ❑Gradual Onset	When did symptom first occur? _____ **Doctor's Notes:** _____

Pain Pattern:	**Pain Aggravated By:**		**Pain Relieved By:**	**Prior Intervention:**
❑Worse in Morning ❑Worse in Afternoon ❑Worse in Evening ❑Worse when Sleeping	❑Bending ❑Coughing/Sneezing ❑Getting up from chair ❑Walking ❑Lifting	❑Twisting ❑Lying down ❑Standing ❑Sitting	❑Stretching ❑Rest ❑Lying Down ❑Standing ❑Ice ❑Knees Bent	❑OTC Medicines ❑Prescription medicine ❑Massage ❑ Surgery ❑Chiropractic Care

Please Mark Applicable Areas for this Condition:



SYMPTOM 2

Symptom:

Area of irritation:_____ **Doctor's notes:**_____

Pain rating (1-10, with 10 being worst imaginable):
❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Main impaired activity made more difficult by above symptom:

Pain Quality:	**Pain Frequency:**	**Pain Radiates Into:**	**Pain Cause:**	**Pain Duration:**
❑Aching ❑Burning ❑Cramping ❑Numbness ❑Sharp ❑Shooting ❑Stiffness ❑Tingling	❑Constant ❑Frequent ❑Intermittent ❑Occasional	❑Arm ❑Leg ❑Shoulder ❑Buttock ***And*** ❑Right Side ❑Left Side ❑Both Sides	❑A Fall ❑Auto Accident ❑Lifting Injury ❑Unknown ❑Gradual Onset	When did symptom first occur? _____ **Doctor's Notes:** _____

Pain Pattern:	**Pain Aggravated By:**		**Pain Relieved By:**	**Prior Intervention:**
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Please Mark Applicable Areas for this Condition: