Solutions Patient Information

Name _____ Date of Birth: _____ Today's Date: _____

SSN: _____ Gender: Male ☐ Female ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ☐

Work Status: Employed ☐ Student ☐ Retired ☐ Other ☐

Employer: _____

Whom may we thank for referring you? _____

Race: American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐

Native Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Ethnicity: Hispanic or Latino yes ☐ no ☐

Primary Language: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Main Phone:_____ Cell ☐ Home ☐ Work ☐ Other ☐

Other Phone: _____ Cell ☐ Home ☐ Work ☐ Other ☐

Emergency Contact: _____ Phone: _____

Guardian name_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____

Parent or Guardian Date

Do you have Primary Medical insurance? Yes ☐ No ☐

Do you have Secondary Medical insurance? Yes ☐ No ☐

Relationship to insured: Self ☐ Spouse ☐ Child ☐ Other ☐

If you did not check 'Self', please provide information below:

Name of Insured: _____

Insured's Date of Birth:_____ Insured's SSN: _____

Insured's Gender: Male ☐ Female ☐

Insured's Employer: _____

Employer Address: _____

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Name _____ Date of Birth: _____ Today's Date: _____

Employer:_____ Occupation: _____

Height: _____Weight: _____ Shoe Size: _____Shoe Width: reg ☐ wide ☐

Use of Alcohol, Tobacco, Drugs? (list type, frequency or amount): _____

_____

Daily Requirements: Walking ☐ Lifting ☐ Sitting ☐ Standing ☐ Other ☐

_____

Allergies: _____

Previous Hospitalizations / Surgeries / Serious Illnesses Approximate Date Hospital or City & State

_____ _____ _____

_____ _____ _____

Previous: Motor Vehicle Accidents Broken Bones Knocked Unconscious Stitches?

_____ _____ _____

_____ _____ _____

List Major Medical Conditions of immediate family members (Mom, Dad, siblings, children) _____

_____

Primary Complaint (please list one main problem): _____

Current Pain level 1-10 _____ How and when did this injury occur? What events led up to it (fall, overuse ect.)? _____

_____

How does the chief complaint interfere with your life or what causes the pain (sleep disturbance, job performance, family relationships, emotional states, sports or hobbies, putting on clothing, bucking seatbelt, reaching for objects, stairs ect.? _____

_____

_____

_____

What have you tried to help the condition? (ice, heat, chiropractor, meds, injections, surgeries ect.)

_____

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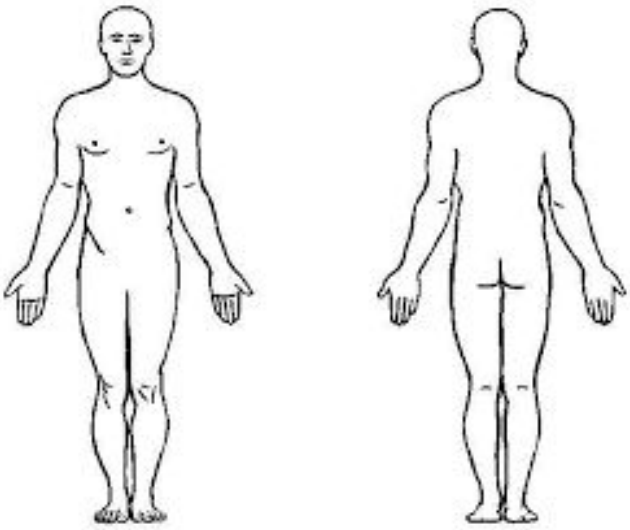
Did these things help?

_____

Mark All areas of pain or discomfort



List each area marked above: How Long? Rate your pain 1-10

1st Complaint _____ _____ _____

2nd Complaint _____ _____ _____

3rd Complaint _____ _____ _____

4th Complain _____ _____ _____

REVIEW OF SYSTEMS (please circle) current or past problems:

Musculoskeletal – Joint pain, stiffness, joint swelling, difficulty moving or walking, dry mouth, sore eyes, back or neck pain, muscle pain, frequent falls, gout, muscle sprains, other _____

_____

Respiratory/cardiac: shortness of breath, cough, wheezing, night sweats, fever, skipping heart beats, blue fingers, toes, other _____

_____

Neurologic: Seizures, tremor, involuntary movement, numbness, tingling, shooting pain, depression, other

_____

GI: nausea, vomiting, constipation, diarrhea, acid reflux, other _____

_____

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Endocrine: Thyroid trouble, heat/cold intolerance, diabetes, other _____

_____

Skin: Rashes, change in hair or nails, other _____

_____

General: Arthritis, autoimmune disease, cancer, obesity, other _____

_____

Current Medications, Prescription and/or Over-the-Counter: (you may bring a list or your medications)

- _____
- _____
- _____
- _____

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Neurological		**General**	
Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Migraines	1 2 3 4 5	Malaise	1 2 3 4 5
Dizziness	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Numbness	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Tingling	1 2 3 4 5	Irritability	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5	Constipation	1 2 3 4 5
Feeling foggy	1 2 3 4 5	Diarrhea	1 2 3 4 5
Forgetfulness	1 2 3 4 5		

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Asthma	1 2 3 4 5	Sore throat	1 2 3 4 5	Frequent Sneezing	1 2 3 4 5
Muscle Aches	1 2 3 4 5	Joint Pain	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Chronic Cough	1 2 3 4 5	Itchy/Watery Eyes	1 2 3 4 5
Fibromyalgia	1 2 3 4 5	Low Back Pain	1 2 3 4 5	Elbow Pain	1 2 3 4 5
Hay Fever	1 2 3 4 5	Chest Congestion	1 2 3 4 5	Drainage	1 2 3 4 5
Arthritis	1 2 3 4 5	Neck Pain	1 2 3 4 5	Shoulder Pain	1 2 3 4 5

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Earache or Ear Infection	1 2 3 4 5	Hoarseness	1 2 3 4 5	Wheezing	1 2 3 4 5
Hip Pain	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5		
Itching	1 2 3 4 5	Shortness of Breath	1 2 3 4 5		
Knee Pain	1 2 3 4 5	Pain b/t shoulder blades	1 2 3 4 5		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian **Date**

_____ _____

Signature of Doctor **Date**

We are really glad you came, you made the right decision.

*This is the place for you to **"regain your life!***
