MT. ROSE CHIROPRACTIC
Curtis R. Potts, D.C., Chiropractic Neurologist

Please list your major complaints in order of severity:

1. _____ 3. _____
2. _____ 4. _____

Complaint **#1** Have you had this or similar conditions in the past? Y N
How did it happen?_____
How long have you had this condition?_____ Date of onset_____
Is this condition getting better, worse or staying the same? Better Worse Same
Is the pain ☐ Constant ☐ Frequent ☐ Comes and goes
Does the pain radiate down an arm or leg? Yes No Where?_____
Circle the intensity of your pain. Slight Mild Moderate Severe

Please indicate the character of your pain.
A. ☐ Dull B. ☐ Sharp C. ☐ Deep D. ☐ Superficial E. ☐ Pins & Needles
F. ☐ Aching G. ☐ Stabbing H. ☐ Burning I. ☐ Numbness

Please indicate the onset of your condition. ☐ Immediate ☐ Gradual

Please indicate what activities aggravate or make your condition worse.
☐ Sitting ☐ Standing ☐ Coughing ☐ Sneezing ☐ Kneeling
☐ Lying ☐ Twisting ☐ Bending ☐ Lifting ☐ Stooping ☐ Bowel Movement
☐ Pushing ☐ Pulling ☐ Walking ☐ Climbing ☐ Gripping ☐ Other_____

Is the pain worse when ? ☐ Moving about ☐ Not moving about

Please indicate what helps you to relieve the pain.
☐ Lying ☐ Sitting ☐ Walking ☐ Massage ☐ Nothing
☐ Hot Baths ☐ Standing ☐ Rest ☐ Exercising ☐ Icing ☐ Stretching
Other_____

☐ Medication: Please list all medications: prescription or over the counter (Give dosage and frequency):
_____
_____

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other_____
What other doctors have you seen for this condition? Give type of treatment and dates:
_____
Did treatment help or not? Y N

FEMALES ONLY
When was your last period?_____ days. Are you pregnant? Y N

Below is a list of conditions which must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibly of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE OR HAVE HAD:

☐ Whooping Cough	☐ Small Pox	☐ Hepatitis	☐ Scarlet Fever	☐ Chicken Pox	☐ Diptheria
☐ Rheumatic Fever	☐ Pneumonia	☐ Polio	☐ Malaria	☐ Tuberculosis	☐ Anemia
☐ Venereal Infection	☐ Cancer	☐ Measles	☐ Mumps	☐ Appendicitis	☐ Diabetes
☐ Typhoid Fever	☐ Alcoholism	☐ Goiter	☐ Influenza	☐ Heart Disease	☐ Pleurisy
☐ Mental Disorder	☐ Arthritis	☐ AIDS	☐ Epilepsy	☐ Lumbago	☐ Eczema

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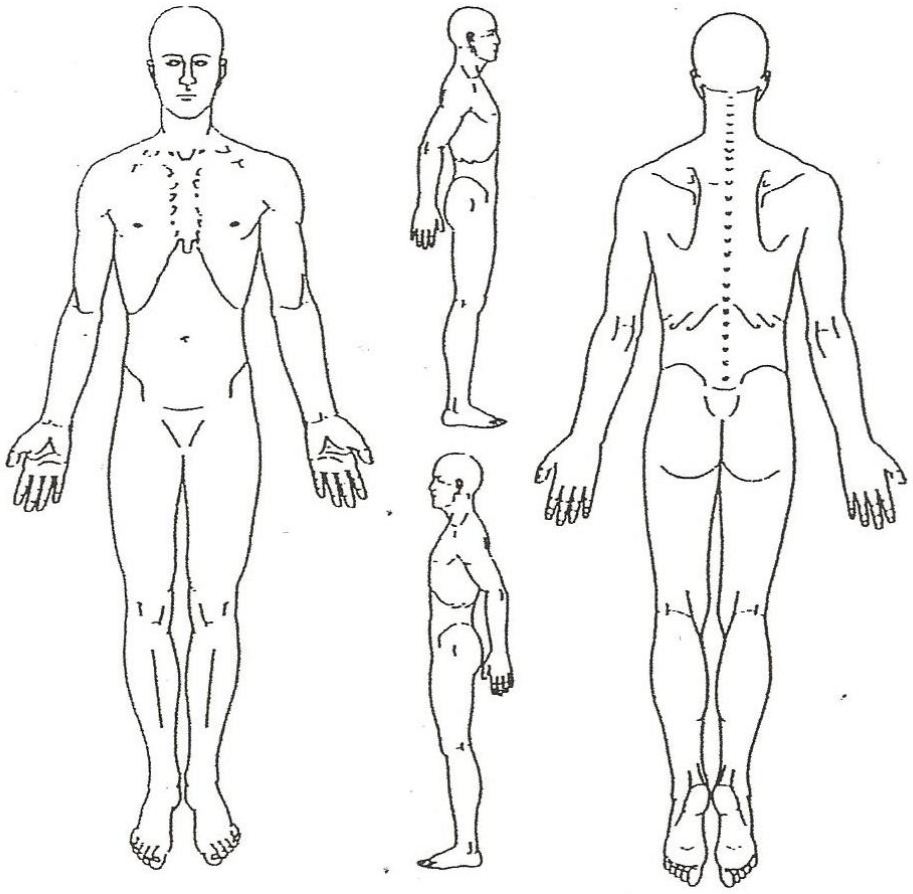
MARK THE AREAS OF PAIN ON THE DIAGRAMS BELOW

Circle the area and then draw a line to the side and use as many of the abbreviations listed below to describe all sensations you are experiencing.

KEY: A = ACHINESS B = BURNING N = NUMBNESS T=TINGLING
P = PINS & NEEDLES S = STABBING O = OTHER



How long has it been since you felt really good?_____
Do you sleep on your ☐ Stomach ☐ Side ☐ Back ☐ Toss & turn
Age of Mattress_____ ☐ Comfortable ☐ Uncomfortable Do you use a bed board? Y N

HAVE YOU EVER:	YES	NO	
Been knocked unconscious?	☐	☐	_____
Been treated for a spine or nerve disorder?	☐	☐	_____
Been hospitalized for other than surgery?	☐	☐	_____

DO YOU:	YES	NO	**DESCRIBE BRIEFLY:**
Now take vitamins or mineral?	☐	☐	_____
Have any allergies?	☐	☐	_____

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal Examination	☐	☐	☐	☐
Physical Examination	☐	☐	☐	☐
Blood Test	☐	☐	☐	☐
Spinal X-Ray	☐	☐	☐	☐

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CHECK ANY OF THE FOLLOWING YOU HAVE

MUSCULO-SKELETAL

☐ Low Back Pain ☐ Pain Between Shoulder Blades ☐ Neck Pain ☐ Arm Pain
☐ Joint Pain/Stiffness ☐ Difficulty Chewing/Clicking Jaw ☐ Walking Problems

NERVOUS SYSTEM

☐ Changes In Personality ☐ Numbness ☐ Paralysis ☐ Dizziness ☐ Convulsions
☐ Confusion/Depression ☐ Forgetfulness ☐ Fainting ☐ Irritability
☐ Changes In Handwriting ☐ Cold/Tingling Extremities

GENERAL

☐ Allergies ☐ Loss of Sleep ☐ Fever ☐ Headaches

GASTRO-INTESTINAL

☐ Poor/Excessive Appetite ☐ Excessive Thirst ☐ Frequent Nausea ☐ Vomiting
☐ Gas/Bloating After Meals ☐ Abdominal Cramps ☐ Constipation ☐ Diarrhea
☐ Gall Bladder Problems ☐ Liver Trouble ☐ Weight Trouble ☐ Heartburn
☐ Black/Bloody Stool ☐ Hemorrhoids ☐ Colitis

GENITO-URINARY

☐ Bladder Trouble ☐ Painful/Excessive Urination ☐ Discolored Urine

CARDIOVASCULAR / RESPIRATORY

☐ Blood Pressure Problems ☐ Chest Pain ☐ Heart Problems ☐ Shortness of Breath
☐ Lung Problems/Congestion ☐ Varicose Veins ☐ Ankle Swelling ☐ Irregular Heartbeat

EENT

☐ Vision Problems ☐ Sore Throat ☐ Hearing Difficulty ☐ Ear Aches
☐ Dental Problems ☐ Stuffed Nose ☐ Ringing or buzzing in ears

FEMALE

☐ Menstrual Irregularity ☐ Menstrual Cramping ☐ Vaginal Pain/Lumps
☐ Breast Pain/Lumps ☐ Menopause

MALE

☐ Prostate/Sexual Dysfunction ☐ Genital Herpes

Why Chiropractic? People go to Chiropractors for a variety of reasons. Dr. Potts wants whatever is malfunctioning in your body brought to the highest state of health possible through Chiropractic Care.

THE PURPOSE OF THIS CHIROPRACTIC CLINIC IS TO SUPPORT EACH INDIVIDUAL IN ACHIEVING THEIR OPTIMAL HEALTH AND TO EDUCATE THEM SO THAT THEY MAY UNDERSTAND HEALTH AND CHIROPRACTIC AND IN TURN EDUCATE OTHERS.

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PERSONAL HISTORY

HABITS:	Heavy	Moderate	Light	None	
Tobacco	☐	☐	☐	☐	How many packs per week?_____
Alcohol	☐	☐	☐	☐	How many drinks per week?_____
Coffee	☐	☐	☐	☐	How many cups per week?_____
Drugs	☐	☐	☐	☐	_____
Exercise	☐	☐	☐	☐	How many times per week?_____
Sleep	☐	☐	☐	☐	How many hours per night?_____
Appetite	☐	☐	☐	☐	
Soft Drinks	☐	☐	☐	☐	

How would you rate your eating habits? Excellent Good Fair Terrible

Do you have any allergies? Y N If yes, please explain _____

MEDICAL HISTORY

Please list any conditions you have been treated for prior to this accident. Give dates, the type of treatment received and any residuals you are still having.

Current ongoing health diagnoses ie: Asthma, MS, arthritis etc.

_____

_____

Surgeries ☐ None Write down year and procedure_____

_____

Hospitalizations ☐ None_____

_____

Fractures ☐ None _____

_____

Serious Injuries, Sports Injuries or Traumas ☐ None_____

_____

Work Injuries ☐ None_____

_____

Motor Vehicle Accidents/Injuries ☐ None _____

_____

FAMILY HISTORY

Relationship	Past & Present Health Problems (Cancer, Heart Disease, Diabetes or Hereditary Disease)
Mother: Age_____	_____
Father: Age_____	_____
Brother: Age_____	_____
Sister: Age_____	_____
Mother's mother: Age_____	_____
Mother's father: Age_____	_____
Father's mother: Age_____	_____
Father's father: Age_____	_____

OCCUPATIONAL HISTORY

Occupation:_____ For how long?_____

Previous occupation_____ For how long?_____

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Today's date _____

Patient's name _____ Sex: Male Female

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone_____

Date of Birth _____ Age _____ Social Security # _____

Marital Status: Married / Single / Divorced / Widow / Separated

Occupation _____ E-Mail address _____

Employer's phone #_____

Spouse's Name _____ Parents/Guardian Name _____

Who referred you to our office? _____

Emergency contact person & phone # _____

Primary Ins. Co. Name _____ Insured's name _____

Ins. Payer ID or SS# _____ Ins. Policy # _____

Insurance contact person / adjuster with phone #_____

Secondary Ins. Co. Name _____ Insured's name _____

Ins. Payer ID or SS# _____ Ins. Policy # _____

Who is responsible for your bill? ____ Self ____ Spouse ____ Insurance _____ Other

How will payment be made? ____ Cash ____ Check ____ Credit Card

I understand that insurance will be billed as a courtesy to me. I am still responsible for my deductible, co-payments and any other charges not covered by my insurance. I further understand that this office will make a reasonable effort to collect from insurance, but if the insurance company does not respond within 45 days, I am responsible for the total charges and for following up with my insurance company. I authorize the release of any medical or other information necessary to any insurance claims. I permit this office to endorse co-issued remittance and if I receive any checks in payment of outstanding charges, I agree to endorse them and turn them over immediately for payment on my account. I understand that fees are to be paid at the time of examinations or treatments are received. The signing of this document verifies that the above information is understood and true.

_____

Patient Signature (Parent /Guardian if minor)