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Established Patient History Update

Name:_____ *Date*:_____
(First) *(Middle)* *(Last)*

*Home Address:*_____*City:*_____*St:*____*Zip:*_____

HomePhone:_____*WorkPhone*:_____*CellPhone*:_____

Student Status: ___*FT* ___*PT* *Employment Status:* ___*FT* ___*PT* *Marital Status:* ___ *S*___*M*___*D*

*SSN:*__ __ __-__ __-__ __ __ __ *Date of Birth:* _____/_____/_____ *Sex:* __ *M* __ *F*

Spouse's Name: _____*Best Contact Number:*_____

*Emergency Contact:*_____*Phone:*_____

Email Address: _____

Payment Information

I will be paying today by: ☐ Cash ☐ Check ☐ Credit Card ☐ Auto Insurer ☐ WC insurer

I authorize Pietila Chiropractic, LLC the release of any medical or other information necessary to process this claim. I request payment of medical benefits from either a government or non-government source to Pietila Chiropractic, LLC. I authorize Pietila Chiropractic, LLC to initiate a complaint to the Insurance Commissioner on my behalf. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I further understand that I will be legally responsible for all collection costs involved with the collection of this account including court costs, reasonable attorney fees and all other expenses incurred with collections, if I default on this agreement. In addition, if I issue a check that is returned by the bank for non-sufficient funds, I understand I will be charged $30.00 for each returned check. If I choose to use my non-contract insurance company I will be considered a cash patient by Pietila Chiropractic. Payment for professional services are due at the time of service. After paying in full I will receive a receipt with the appropriate billing and diagnosis codes to submit to my insurance company myself. My insurance company will reimburse me directly. I certify the information above is true and correct to the best of my knowledge.

Signature: _____ Date: _____

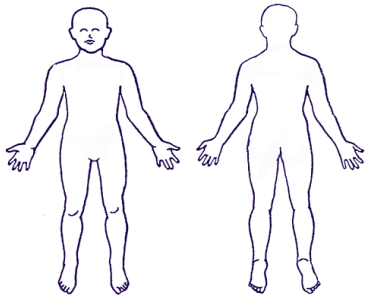
Name:_____ DOB:_____

Chief Complaint – Present Condition

When did your complaints and/or symptoms begin? _____
Describe your current injury or your current problem: _____
_____

Please mark your symptoms on the diagram.

Aching – XXX
Burning - ###
Numbness - ///
Pins/Needles – 000
Stabbing - ●●●



Rate your pain right now (mark as "N"); worst (mark as "W"); best (mark as "B")

0 1 2 3 4 5 6 7 8 9 10

⇐_____⇒

no pain mild moderate severe very severe worst possible

Please check all present symptoms related to your current condition:

Head & Face

__ base of skull __ side/temple __nausea/vomiting __ ear pain __throbbing __ migraine
__ incapacitating __ front __ ringing in ears __ nose bleeds __ eyelids heavy __ top
__ double vision __ pressure __ head feels heavy __ eye pain __ jaw pain __ flushing
__ light sensitive __ blurry vision __ headache affects vision __ dizziness __ sinus problems

Neck

__ weakness __ spasms __ pain on motion __ limited motion __ pain __ swelling
__ lumps __ throat tight __ radiating pain __ difficulty swallowing __ stiffness

Shoulder, Arm & Hand

Shoulder: __ local pain __ limited movement __ pain on movement __ pain from neck __ radiates down arm
Arm & Hand: __ local pain __ pain on movement __ swelling __ cold hands __ weakness
__ radiates from neck __ numbness/tingling __ cannot raise arm

Mid-back & Low-back

__ weakness __ pain __ spasms __ rib pain __ chest pain __stiffness __ swelling __ pain on motion
__ limited motion __ radiating pain

Hips, Legs, Knees and Feet

__ local pain __ radiating __ from back __ down leg __ swelling __ numbness __ tingling __ spasms
__ cramping __ cold feet __ weakness __ pain on motion __ varicose veins

Nerves

__ burning __ numbness __ tingling __ tremor __ dizziness __ loss of balance __ loss of consciousness
__ coordination __twitching __difficulty with memory __seizures __ generalized weakness

Sleep

__ good __ fair __ poor __ poor due to pain __ deep burning pain
__ difficulty falling asleep __ difficulty staying asleep __ wake often

Fatigue

__ must rest during day __ cannot get enough rest __ intermittent fatigue __ constant fatigue
__ worse with exercise __ mental fatigue __ physical fatigue

Name:_____ DOB:_____

Past Medical History

Please mark any of the following that you have experienced in the ***past 6 months***

Head, Ears, Eyes, Nose and Throat

☐ vision problems ☐ eye pain ☐ hearing difficulty ☐ dental problems ☐ headaches
☐ earache/infections ☐ sore throat ☐ ringing in ears ☐ sinus congestion ☐ nose bleeds
☐ bleeding in gums/lips ☐ loss of smell ☐ poor night vision

Cardiovascular and Respiratory

☐ chest pain/tightness ☐ low blood pressure ☐ fainting ☐ shortness of breath ☐ cold hands/feet
☐ high blood pressure ☐ varicose veins ☐ dizziness ☐ swelling of legs/feet ☐ coughing blood
☐ lung problems ☐ persistent cough ☐ light headed ☐ irregular/fast heartbeat

Gastrointestinal

☐ nausea ☐ vomiting ☐ heartburn ☐ gas/bloating ☐ bloody stools
☐ esophageal reflux ☐ constipation ☐ hemorrhoids ☐ ulcers ☐ diarrhea
☐ gallbladder problems ☐ bowel incontinence ☐ abdominal pain/cramps

Genitourinary

☐ pain with urination ☐ frequent urination ☐ kidney stones ☐ loss of bladder control ☐ infection
☐ wake to urinate ☐ blood in urine ☐ sexual dysfunction ☐ urgency with urination ☐ STD

Male/Female Systems

☐ prostate problems ☐ irregular periods ☐ sexual dysfunction ☐ vaginal pain/infection ☐ menopause
☐ menstrual cramps ☐ breast pain/lumps __ # of pregnancies __ # of live births __ # of C-Sections

Musculoskeletal

☐ joint pain ☐ muscle pain ☐ back stiffness ☐ joint stiffness ☐ back pain
☐ muscle stiffness ☐ joint swelling ☐ difficulty with limb movement

Nervous System

☐ nervousness/anxiety ☐seizures/convulsions ☐ dizziness ☐ depression ☐ forgetfulness
☐ confusion ☐ paralysis ☐ numbness/tingling ☐ weakness

General

☐ weight loss ☐ weight gain ☐ night sweats ☐ excessive thirst ☐ chills
☐ fever ☐ insomnia ☐ fatigue ☐ bruise/bleed easily ☐ itching
☐ spots on fingernails ☐ fragile/brittle nails ☐ headaches ☐ skin rash/sores ☐ other _____

Have you been hospitalized at any time since your last visit? ☐ Yes ☐ No
If so, where and when? _____
_____

Please list your surgery(ies)

Date	Type of Surgery	Results

Are you taking any medication? ☐ Yes ☐ No If yes, please complete table below:

Medication Name	Dosage	How Often Taken	How long have you been taking this medication?

Are there any medications you have had an allergic reaction or unpleasant side effects? _____
_____

Are you currently taking any supplements? ☐ Yes ☐ No If yes, please complete table below:

Supplement Name	Dosage	How Often Taken	How long have you been taking this medication?

Have you had an allergic reaction to the following?

☐ latex and rubber ☐ bee or wasp stings ☐ adhesive tape
☐ iodine or x-ray contrast dye ☐ influenza vaccination ☐ other: _____

Do you have any updated food allergies? ☐ Yes ☐ No If yes, please list: _____
_____
_____

Upon signature of this document I am certifying that all the information provided is true, correct and complete. If more information about my illness becomes known, I will tell the doctor when possible so that it can be added to my record.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____
(please sign, print your name and relationship to the patient)