Mt. Olive Chiropractic Clinic

515 West main Street
Mt. Olive, NC 28365
919-658-0003

Today's Date:_____/_____/_____

Name:_____ D.O.B._____/_____/_____ Age:_____

Preferred Name:_____ SS#_____ Sex: ☐Male ☐Female

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

Home #_____-_____-_____ Cell #_____-_____-_____ Work #_____-_____-_____

☐Married ☐Single ☐Other:_____ #Children?_____ Ages:_____

Email:_____ How Did You Hear About Us?_____

Employer:_____ Occupation:_____

Work Address: :_____ City:_____ State:_____ Zip:_____

Spouse/Parent Name:_____ Phone#_____-_____-_____

Spouse/Parent Employer:_____ Work#_____-_____-_____

Emergency Contact:_____ Phone# _____-_____-_____

Reason For Your Visit

☐Pain Symptoms ☐Wellness Visit ☐Auto Accident ☐Work Related Injury

☐Sports Injury ☐Other Injury:_____

Date of Injury/Onset of Symptoms:

Primary Symptoms (check all that apply):

☐Headache	☐Migraines	☐Neck Pain	☐Neck Stiffness	☐Mid-Back Pain
☐Low Back Pain	☐Arm Pain L/R	☐Leg Pain L/R	☐Hip Pain L/R	☐Upper Back Pain
☐Fatigue	☐Discomfort	☐Weakness	☐Tingling	☐Soreness
☐Shoulder Pain L/R	☐Elbow Pain L/R	☐Tension	☐Head Feels Heavy	☐Knee Pain L/R
☐Pins/Needles in the Arms & Legs	☐Numbness in Toes/Fingers			

Additional Symptoms:_____

Describe Your Pain & Circle on the Picture (check all that apply):

Severity:
Mild Mild to Mod Moderate Mod to Severe Severe

Frequency:
Once Intermittent Occassional Frequent Constant

Quality:
Dull Medium Sharp Stabbing Burning

Pain Is Worse:
Morning Midday After Work Evening Night

Symptoms Increase With:
Work Activity Exercise Rest Sitting Standing
Bending Walking Other

Describe on a scale of 0 (no pain) to 10 (severe pain) "How do I feel?"

Circle: 0 1 2 3 4 5 6 7 8 9 10

Overall, how do you feel?_____

Your Medical Doctor:_____ **Last Exam:**_____

List Any Current Allergies:_____

Current Medications You Are Taking:_____
_____

Surgeries & Procedures:_____
_____

Have you recently slept on: your stomach a couch a new bed the floor a recliner?

Have you recently taken a long trip? Duration of trip?_____ Mode of Transportation?_____

Have you had chiropractic care before? ☐Yes ☐No If yes, with whom?_____

Have you seen other doctors for your condition? ☐Yes ☐No If yes, whom?_____

Have you had this problem in the past? ☐Yes ☐No When/How Often?_____

Have you lost time from work due to your condition? ☐Yes ☐No Dates: _____

Do you smoke? ☐Yes ☐No If yes, how much?_____# per day

Do you drink alcohol? ? ☐Yes ☐No If yes, how much?_____# per day/week/month

Exercise? ☐Yes ☐No How often?_____ Type:_____

Are you pregnant? ☐Yes ☐No Due Date:_____ Doctor:_____

Date of last menstral cycle?_____ # of Pregnancies:_____ # of Miscarriages:_____

Your Medical History: (Check all that apply) **Y=Yourself F=Family Member**

Y F

☐ ☐Fatigue	☐ ☐Dizziness/Vertigo	☐ ☐Fainting	☐ ☐Cold Hands
☐ ☐Cold Feet	☐ ☐Hand Tremors	☐ ☐Nausea	☐ ☐Diarrhea
☐ ☐Constipation	☐ ☐Varicose Veins	☐ ☐Stroke	☐ ☐Difficulty Breathing
☐ ☐Coughing Blood	☐ ☐Bleeding	☐ ☐Sweats	☐ ☐Pregnancy
☐ ☐Prostate Problem	☐ ☐Heart Attack	☐ ☐Circulatory Problem	☐ ☐High Blood Pressure
☐ ☐Low Blood Pressure	☐ ☐Ulcers	☐ ☐Heart Problem	☐ ☐Pacemaker
☐ ☐Diabetes	☐ ☐Alzheimer's	☐ ☐Gallbladder Problem	☐ ☐Digestive Problem
☐ ☐Eczema	☐ ☐Convulsions	☐ ☐Tumors	☐ ☐Seizures
☐ ☐Epilepsy	☐ ☐Tinnitus	☐ ☐Headaches	☐ ☐Migraines
☐ ☐Eye/Vision Problem	☐ ☐Ear/Hearing Problems	☐ ☐Arthritis	☐ ☐Osteoarthritis
☐ ☐Rheumatoid Arthritis	☐ ☐Osteoporosis	☐ ☐AIDS/HIV	☐ ☐Congenital Disease
☐ ☐Ruptures	☐ ☐Disc Disorder	☐ ☐Speech Difficulty	☐ ☐Loss of Memory
☐ ☐Confusion	☐ ☐Nervousness	☐ ☐Anxiety	☐ ☐Mental Illness
☐ ☐Irritability	☐ ☐Tension	☐ ☐Depression	☐ ☐Insomnia
☐ ☐Eating Disorder	☐ ☐Alcoholism	☐ ☐Drug Addiction	☐ ☐Scoliosis
☐ ☐Tonsillitis	☐ ☐Kidney Disorder	☐ ☐Gout	☐ ☐Amputation
☐ ☐Chills	☐ ☐Earache	☐ ☐Sciatica	☐ ☐Neuralgia
☐ ☐Vomiting	☐ ☐Hemorrhoids	☐ ☐Bursitis	☐ ☐COPD
☐ ☐Broken Bones	☐ ☐Neuromuscular Dis.	☐ ☐Bladder Control Loss	☐ ☐Bowel Control Loss
☐ ☐Cancer	☐ ☐Other:	☐ ☐Other:	☐ ☐Other:

Which activities are difficult due to your pain/discomfort?: (Check all that apply)

☐Sleeping	☐Walking	☐Standing	☐Sitting	☐Running
☐Climbing	☐Bathing	☐Showering	☐Dressing	☐Shoes
☐Toileting	☐Cleaning	☐Self Care	☐Family Care	☐Child Care
☐Home Care	☐Driving	☐Gardening	☐Working	☐Lifting
☐Desk Work	☐Traveling	☐School	☐Concentrate	☐Other:

How are your daily activities affected by your condition?_____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself—not between my insurance company and this office. I agree to pay my estimated copay at the time services are rendered, including my deductibles, and I further understand that the estimated copay is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my copay as determined by my insurance company upon processing my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable amount of time upon request by this office, I will immediately pay the balance on my account. I further understand and agree that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including but not limited to, all court costs and attorney fees. I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney(s) who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys or other payers. I have read, understood and agree to the foregoing. The information I have provided is true and complete, to the best of my knowledge.

Patient's Signature_____ Date:_____/_____/_____