FAMILY CHIROPRACTIC

Rogersville at Riverscape
Aric D. Butler D.C. Quentin G. Hendrix D.C.
Phone: 256-247-4000 / 256-229-6992 Fax: 256-483-4826

Patient Intake

Date: ___/___/____

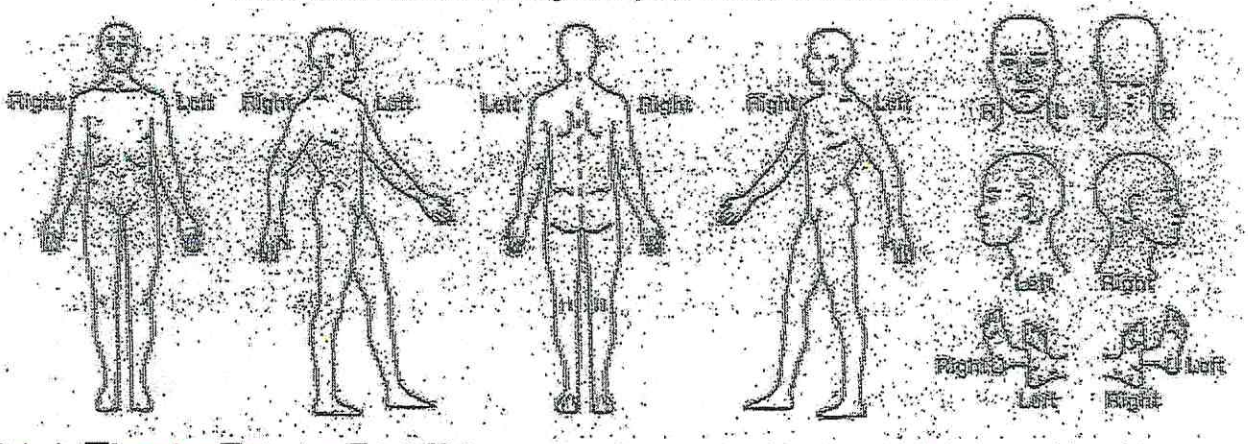
Welcome to Family Chiropractic! In order for us to best meet your healthcare needs, please fill out the following form thoroughly.

Which Doctor will you be seeing today? ☐Aric D. Butler D.C. ☐Quentin G. Hendrix D.C.

Patient's Name: First_____ MI_____ Last_____
Address: _____ City_____ State_____ Zip_____
DOB: ___/___/____ SS#:_____ ☐Married ☐Single ☐Widow ☐Male ☐Female
Height:_____ Weight:_____ Number of Children:_____
Home # _____Cell # _____(wireless carrier)_____
Work#_____ Email: _____
Would you like to receive appointment reminders? Yes_____ No_____
If yes (choose only one) Text_____ or Email_____
Spouse's Name: First_____ MI_____ Last_____
Spouse's DOB:___/___/____ Spouse's SS#:_____Spouse's Phone #:_____
Emergency Contact: Name_____ Phone #:_____
Relationship to Patient _____
Referred to this office by: ☐Doctor ☐Existing Patient ☐Reference's name_____
Primary Care Physician:_____ City/State: _____

What is the reason for this visit? _____ When did this condition begin?_____
Is this visit related to an accident or a specific event? ☐No ☐Work ☐Auto ☐Other _____
Date of injury: ___/___/____

Please indicate on the diagrams your area(s) of discomfort.



Pain is ☐burning ☐stinging ☐dull ☐sharp ☐occasional ☐constant

On a scale of 1-10, with 10 being unbearable, what is the severity of your pain?_____

Describe the onset of the discomfort? ☐Gradual ☐Insidious ☐Recent ☐Spontaneous ☐Sudden ☐Traumatic ☐Unknown

Describe the quality of the discomfort. Choose all that apply.

- ☐ Aching
- ☐ Annoying
- ☐ Burning
- ☐ Deep
- ☐ Diffuse
- ☐ Dull
- ☐ Heavy
- ☐ Intolerable
- ☐ Pulling
- ☐ Sharp
- ☐ Shock-like
- ☐ Shooting
- ☐ Stabbing
- ☐ Stiffness
- ☐ Throbbing
- ☐ Tightness
- ☐ Tingling
- ☐ Other

Does the pain radiate?_____

What activity is most affected by this discomfort? _____

What aggravates the condition?_____

What improves the condition?_____

What treatment have you received for this condition?_____

Where any diagnostic tests performed to assess this condition (X-ray, MRI, CT, etc.)?

_____

In what ways does the condition affect your life and your ability to function?_____

_____

Do you have an additional complaint?_____

Have you been treated for a similar condition? _____

_____

List your past surgical history._____

_____

_____

Describe any past illnesses or conditions. _____

_____

_____

List any past accidents or trauma._____

_____

_____

List current medications._____

_____

_____

Please indicate all conditions and illnesses that apply. Family refers to parents, siblings, or children.

Condition	You	Family	Condition	You	Family
Jaundice			Diabetes		
Hepatitis			Arthritis		
High Blood Pressure			Gout		
Heart Disease			Alzheimer's		
Heart Attack			Anemia		
Sickle Cell					
Scoliosis			Blood Clots		
HIV/AIDS			Epilepsy		
Stomach Ulcers			Stroke		
Asthma			Cancer		

Please explain any checked boxes. _____

_____

Please indicate any symptom you currently have or have experienced within the past 60 days.

- ☐ Headache/Migraine
- ☐ Concentration/Memory Loss
- ☐ Sensitivity to light
- ☐ Memory loss
- ☐ Light/Heavy feeling in head
- ☐ Dizziness
- ☐ Ringing in ears
- ☐ Loss of balance
- ☐ Loss of taste/smell/hearing
- ☐ Heartburn/indigestion
- ☐ Pain behind eyes
- ☐ Heart racing
- ☐ Fainting
- ☐ Neck pain/stiffness
- ☐ Neck motion restricted
- ☐ Upper back pain/stiffness
- ☐ Mid-back pain/stiffness
- ☐ Low back pain/stiffness
- ☐ Back motion restricted
- ☐ Shoulder pain
- ☐ Arm pain
- ☐ Leg pain
- ☐ Numbness/tingling in arms
- ☐ Numbness/tingling in hands
- ☐ Numbness/tingling in legs
- ☐ Numbness/tingling in feet
- ☐ Blurry/Double vision
- ☐ Sinus problem
- ☐ Chest pain
- ☐ Short of breath
- ☐ Irritability
- ☐ Anxiety/depression
- ☐ Insomnia
- ☐ Fatigue
- ☐ Flushed/pale face
- ☐ Nervousness
- ☐ Constipation
- ☐ Nausea
- ☐ Diarrhea
- ☐ Swelling
- ☐ Bruising
- ☐ Jaw Pain
- ☐ Broken Bones
- ☐ Surgery
- ☐ Auto accident
- ☐ Fall
- ☐ Other accident
- ☐ Hospitalization
- ☐ Other major procedure

What are your current work habits (Occupation, general job description)?

_____

Social Habits? ☐Alcohol ☐Tobacco ☐Illicit Drugs Present Exercise Habits?_____

Have you received chiropractic care before?_____ Doctor's name_____

Females: Are you pregnant? ☐Yes ☐No ☐Not sure Last Period?_____

Authorization

I certify that I am the patient or legal guardian listed above, and I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment examination rendered to me or my child during the period of such chiropractic care to third party payers, insurance company, attorney, adjuster and/or health practitioners. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf for my dependents, and pay within a timely matter. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

X_____

Signature of Patient (or parent of minor) Date

Rogersville Family Chiropractic

Aric D. Butler, D.C.

17520 Hwy 72, P.O. Box 219

Rogersville, AL 35652

256-247-4000

CONTACT INFORMATION SHEET

Patient Name: _____

Social Security Number: _____

Any physician, staff, employee, or representative of Rogersville Family Chiropractic has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information with the following persons:

Name	Relationship	Phone #

□ I do not want anyone to have access to my protected health information unless I provide explicit authorization

If unable to reach me:

□ You may leave a detailed message.
□ Please leave a message asking me to return your call.
□ Do NOT leave a message.

IF ANY INFORMATION ON THIS FORM CHANGES, IT IS THE PATIENT'S RESPONSIBILITY TO NOTIFY ROGERSVILLE FAMILY CHIROPRACTIC IMMEDIATELY.

_____ _____

Signature Name of Patient Date

_____

Printed Name of Parent/Patient's Representative (If Applicable)

_____

Signature of Parent/Patient's Representative (If Applicable)

_____

Employee Witness