WELCOME

Lyon County Chiropractic

706 S Ninth Ave., Rock Rapids, IA 51246
(712) 472-4732

Date: ___________________________________

Patient Information

Name: ____________________________________

Address:___________________________________
____

Sex: Male______ Female_______Age:_________

Birth date: ___/___/___ ___Married ___Divorced

___Single ___Widowed ___Separated

Social Security # ______ - ____ - ______

Home Phone #: (______) ______-________

Best Time to reach you: _________ a.m. / p.m.

Emergency Contact: _________________________

Emergency Contact Phone #: _________________

Occupation: ________________________________

Employer: _________________________________

Employer Phone: ____________________________

Spouse Name: ______________________________

Spouse Birthdate: ___________________________

Spouse Occupation: _________________________

Whom can we thank for referring you to our office? ____________________________________

Insurance

Who is responsible for account: __________

Insurance Company: ___________________

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________________ and I/we assign directly to Dr. ___________________ all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission

____
Responsible Party Signature

_________________________ ___________
Relationship Date

Accident Information

Is the condition due to accident __Yes __No

Type of accident __Auto __Work ___ Home

To whom did you report accident? _______
____

Patient Condition

Reason for visit: ____

In your own words where is the problem? ____

When did your symptoms appear? ____

Is the condition getting ____better ____worse ____stays the same ____unsure

1 (least pain) to 10 (most pain) rate your discomfort: ______

Describe the pain ___numb ___tingling ___weakness ___sharp ___dull ___throbbing ___aching ___shooting ___burning ___cramping ___stiff ___swelling ___other please describe _________

How often do you have the pain? ___________________________

Is the problem/pain constant or does it come and go? _________________________

Does it interfere with the following? ____ work ____sleep ____ trouble getting comfortable at night ____ daily routine ____recreational activities

Which if any of the following are difficult to perform: ____ sitting ____standing ____walking ____bending ____lying down ____ coughing ____sneezing ____bowel movements

Patient Symptoms *(please X any of the following you are experiencing)*

Are you having any of the following symptoms: ____arm/shoulder pain ____back pain ____back stiffness ____chest pain ____dizziness ____ear buzzing/ringing ____fatigue ____feet/toe numbness ____hand/finger numbness ____headaches ____irritability ____jaw problems ____leg pain ____memory loss ____nausea ____neck pain ____neck stiffness ____shortness of breath ____sleep difficulty ____stomach upset ____tension ____blurry vision ____double vision

Past Health History

What treatment(s) have you received for this condition? ____Medical ____Medication ____Surgery ____Physical Therapy ____Chiropractic ____Accupuncture ____ None ____Other

Name of provider who gave previous services? _______________________________________

Date of last: Physical Exam ________ Spinal Exam ________ Blood Test ________
Spinal X-ray __________ Chest X-ray __________ Urine Test __________
Dental X-ray ___________ MRI __________ CT Scan __________
Bone Scan __________

Please Mark Yes or No if you have had any of the following conditions:

AIDS/HIV	___Yes ___ No	Emphysema	___Yes ___No	Miscarriage	___Yes ___No
Alcoholism	___Yes ___ No	Epilepsy	___Yes ___No	Mononucleosis	___Yes ___No
Allergy Shot	___Yes ___ No	Fractures	___Yes ___No	Multiple Sclerosis	___Yes ___No
Anemia	___ Yes ___ No	Glaucoma	___Yes ___No	Mumps	___Yes ___No
Anorexia	___ Yes ___ No	Goiter	___Yes ___No	Osteoporosis	___Yes ___No
Appendicitis	___ Yes ___ No	Gout	___Yes ___No	Pacemaker	___Yes ___No
Arthritis	___ Yes ___ No	Gonorrhea	___Yes ___No	Parkinson’s	___Yes ___No

Asthma ___ Yes ___ No	Heart Disease ___Yes ___No	Pinched Nerve ___Yes ___No
Bleeding ___ Yes ___ No	Hepatitis ___Yes ___No	Pneumonia ___Yes ___No
Breast Lump___ Yes ___ No	Hernia ___Yes ___No	Polio ___Yes ___No
Bronchitis ___ Yes ___ No	Herniated Disc ___Yes ___No	Prostate problem ___Yes ___No
Bulimia ___ Yes ___ No	Herpes ___Yes ___No	Prosthesis ___Yes ___No
Cancer ___ Yes ___ No	High Cholest. ___Yes ___No	Psychiatric Care ___Yes ___No
Cataracts ___ Yes ___ No	Kidney Disease___Yes ___No	Rheumatoid ___Yes ___No
Drug Abuse ___ Yes ___ No	Liver Disease ___Yes ___No	Rheumatic Fever ___Yes ___No
Chicken Pox___ Yes ___ No	Measles ___Yes ___No	Scarlet Fever ___Yes ___No
Diabetes ___ Yes ___ No	Migraines ___Yes ___No	Stroke ___Yes ___No
Suicide Try ___ Yes ___ No	Tonsilitis ___Yes ___ No	Thyroid Problem ___Yes ___No
Tumors ___ Yes ___ No	Growths ___Yes ___ No	Tuberculosis ___Yes ___No
Ulcers ___ Yes ___ No	Whoop Cough ___Yes ___No	Vaginal Infection ___Yes ___No
		High Blood Pressure ___Yes ___No

Please list any of the following you have had:
Falls: ____
Head Injuries: ____
Broken Bones: ____
Dislocations: ____
Surgeries: ____

Social History

Which best describes your exercise level: ____None ____Moderate ____Daily ____Heavy ____Cardiovascular ____Physical work

Which best describes your work activity: ____Sitting ____Standing ____Light Labor ____Heavy Labor

Do you Smoke (YES / NO) If so how long? __________ How many packs/day? ____________

Do you drink alcohol (YES / NO) If so how many drinks/week? _________________________

Do you drink coffee/caffeine (YES / NO) If so how many cups/drinks per day? ____________

How would you describe your stress level? (LOW / MODERATE / HIGH) Why? ___________

Are your Pregnant? (YES / NO) If so when is your expected due date? ___________________

Medications/Allergies/Vitamins/Herbs/Minerals

Please list any medications you are currently taking: _________________________________
____
Please list any known allergies: ____
Please list any current vitamins/herbs/minerals you are taking: __________________________
____

Family History

Please list if any member of your family (includes parents, grand parents, brothers or sisters) who have had the following:
Cancer: ___________________________ Lupus: ________________ Stroke: ___________
Rheumatoid Arthritis: ________________ Diabetes: ______________ Heart Disease:______
High Blood Pressure: ________________