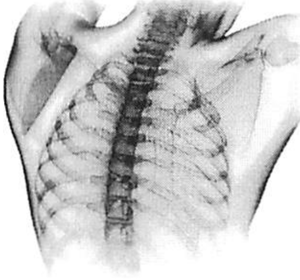


SLAUGHTER LANE CHIROPRACTIC
& THERAPUETIC MASSAGE

David R. Wagner D.C.

Confidential Patient Data

Please allow our staff to photocopy your driver's license and insurance details

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION Today's Date: ______________

Name: ______________________________ Date of Birth: ___-___-___ Age: ________ ☐Male ☐Female

Address: ______________________________ City: ____________ State: ______ Zip: ______________

Email Address: ______________________________

Cell Phone: ____________________ Home Phone: ________________ Work Phone: ________________

Marital Status: ☐Married ☐Single ☐Engaged ☐Divorced ☐Separated ☐Other ______________________

Race (circle one): American Indian or Alaska Native / Asian / Black or African American / White(Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Preferred language: ____________________ Work Status (circle one): Full time / Part time / Retired / Unemployed

Your Occupation ______________________ Your Employer: ______________________________

Emergency Contact: ______________________ Relation: ________________ Phone: ______________

Primary Care Physician: ______________________________

Referred to this Office by: ☐Friend or Family Member → Name? ______________________________

☐PPO/Ins Directory ☐Online/Google ☐Clinic Location ☐Website ☐Other : ______________________

Payment for Services will be by: ☐Cash ☐Check ☐Credit Card

Acknowledgements

Initial_____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation (spinal misalignment). Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initial _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. I choose to decline receipt of my clinical summary after every visit.

Initial _____ I realize that if I need x-rays that this type of examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YY): ______________

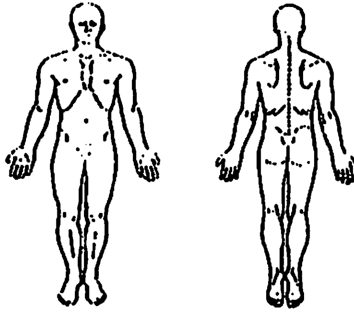
Initial _____ I grant permission to be called, texted or emailed to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initial _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

(Draw on the body where you are having any pain or discomfort and check the words that best describes it)

Doctor's Notes

☐Headache ☐Neck Pain
☐Mid Back Pain ☐Low Back Pain
☐Shoulder Pain ☐Arm Pain
☐Hip Pain ☐Leg Pain
☐Other. ____________



Type of pain.
☐Aching ☐Burning
☐Soreness ☐Tightness
☐Stiffness ☐Sharp
☐Stabbing ☐Shooting
☐Numbness ☐Tingling
☐Pins and needles

Did your problem start?
☐Gradually ☐Suddenly

Date problem began. __________

If no specific date, for how long? #_____Days _____Weeks _____Months _____Years

How problem began. ☐Auto accident ☐Injury at home ☐Sports related ☐Exercise related
☐Repetitive activity ☐Unknown ☐Other ____________

Current pain level (today) (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Pain level the past week (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Frequency of symptoms. (occasional) ☐0-25% ☐26-50% ☐51-75% ☐76-100% (constant)

How much have symptoms interfered with activities?
☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely

What makes your symptoms better?
☐Rest ☐Ice ☐Heat ☐Medication ☐Massage ☐Stretching ☐Sitting ☐Other ____________

Symptoms are worse in the. ☐Morning ☐Afternoon ☐Evening

Since your problem began is it. ☐Getting better ☐Getting worse ☐Staying the same

Activities of Daily Living – How does your condition currently interfere with the activities below?

Activity				Activity			
Sit...............	___Mildly	___Moderately	___Severely	Grocery shopping	___Mildly	___Moderately	___Severely
Rise out of chair	___Mildly	___Moderately	___Severely	Household chores	___Mildly	___Moderately	___Severely
Walk...............	___Mildly	___Moderately	___Severely	Reach overhead...	___Mildly	___Moderately	___Severely
Lay down............	___Mildly	___Moderately	___Severely	Shower/bathing...	___Mildly	___Moderately	___Severely
Bend over.........	___Mildly	___Moderately	___Severely	Dress myself......	___Mildly	___Moderately	___Severely
Climb stairs......	___Mildly	___Moderately	___Severely	Love life............	___Mildly	___Moderately	___Severely
Use a computer	___Mildly	___Moderately	___Severely	Fall asleep......	___Mildly	___Moderately	___Severely
Get in/out of car	___Mildly	___Moderately	___Severely	Stay asleep.........	___Mildly	___Moderately	___Severely
Drive a car.........	___Mildly	___Moderately	___Severely	Concentrate......	___Mildly	___Moderately	___Severely
Look over shoulder	___Mildly	___Moderately	___Severely	Exercise............	___Mildly	___Moderately	___Severely
Care for family...	___Mildly	___Moderately	___Severely	Yard work......	___Mildly	___Moderately	___Severely

Please check all that apply to you. (these may be things we can help you with)

☐ Fatigue ☐Cancer ☐Abnormal weight. ☐Gain ☐Loss
☐ Arthritis ☐Osteoporosis
☐ Weakness ☐Numbness/tingling ☐Seizures
☐ Vertigo/dizziness ☐Ear infections ☐Vision problems
☐ Frequent colds ☐Sinus infections ☐Allergies
☐ High blood pressure ☐Heart problems ☐Leg cramps
☐ High cholesterol ☐Stroke (date) __________
☐ Asthma ☐Breathing problems
☐ Heartburn ☐IBS ☐Constipation
☐ Thyroid problems ☐Diabetes ☐Hormone problems
☐ Excessive thirst ☐Frequent urination
☐ Depression ☐Anxiety
☐ Irregular menstrual cycle ☐Excessive menstrual cramps
☐ Currently pregnant. # weeks __________ Due date. __________

Doctor's Initials. ______

General Health: ☐Poor ☐Fair ☐Good ☐Very good ☐Excellent

Doctor's Notes

Illnesses: Please check all illnesses you have had in the past or have now.

Alcoholism	___had	___have	Hepatitis	___had	___have	Ulcer	___had	___have
Chicken pox	___had	___have	Malaria	___had	___have	Arteriosclerosis	___had	___have
HIV positive	___had	___have	Measles	___had	___have	Multiple sclerosis	___had	___have
Scarlet fever	___had	___have	Mumps	___had	___have	Rheumatic fever	___had	___have
Turberculosis	___had	___have	Polio	___had	___have	Sexually transmitted		
Typhoid fever	___had	___have	Gout	___had	___have	Disease (STD)	___had	___have
Glaucoma	___had	___have	AIDS	___had	___have	Other: ________		

Previous accidents/injuries (work, auto accidents, sports, broken bones, etc):

Body area/approximate date: ______________________________

____

Operations (type/date): ______________________________

____

Medications:

Please list any over the counter and/or prescription medications you are currently taking

Medication Name	Dosage & frequency (Ex: 5mg 1x a day)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Comments

Family History: ☐Cancer ☐Diabetes ☐High Blood Pressure ☐Stroke
☐Heart Disease ☐Rheumatoid arthritis ☐Scoliosis

Do you use any of the following:

Tobacco ___Daily ___ Occasionally ___Former ___Never

Alcohol ___Daily ___ Occasionally ___Former ___Never

Caffeine ___Daily ___Occasionally ___Former ___Never

Exercise: ☐Not at all ☐Regularly Type: ☐Run ☐Walk ☐Gym ☐Swim ☐Yoga ☐Lift weights

Work: ☐Professional ☐Physical labor ☐Drive ☐Clerical ☐Homemaker

Physical demands: ☐Heavy ☐Moderate ☐Light ☐Sedentary

Stress level: ☐High ☐Moderate ☐Low

Sleep on: ☐Stomach ☐Back ☐Side

Quality of sleep: ☐Poor ☐Fair ☐Great

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Doctor's Initials: ______

Signature: ______________________ Date: ______________________