Athens Chiropractic Clinic **Patient Present Complaints**

Name ____________________ Date ____________

Address ____________________ City ____________ State ______ Zip ____________

Telephone ____________ Cell # ____________ Social Security# ____________

Age ______ Birthdate ____/____/____ Sex (M / F) ______ Status (M S W D) ______ No. Children ______

E.mail Address ____________________

Occupation ____________ Employer ____________ Years Employed ____________

Address ____________________ City ____________ State ______ Zip ____________

Work Phone ____________ Ext. ______ Referred By: ____________

Spouse's Name ____________ Person Responsible for this Account ____________

Please describe your problem and how it began: ***Date problem began:*____/____/____**

____

____

How bad is your pain? (Circle a number)	0	1	2	3	4	5	6	7	8	9	10
	No Pain									Unbearable Pain	

How often are your symptoms present?	❑ Constantly	❑ Frequently	❑ Occasionally	❑ Intermittently

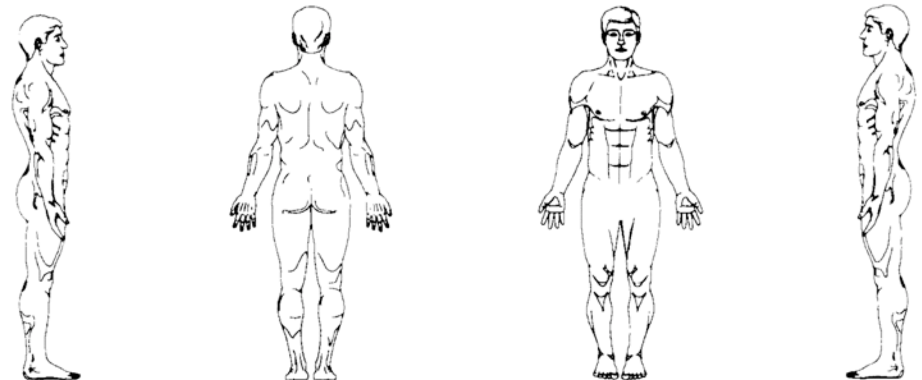
Describe your current pain/symptoms:	❑ Sharp/Stabbing	❑ Throbbing	❑ Aches
	❑ Dull	❑ Soreness	❑ Weakness
	❑ Numbness	❑ Shooting	❑ Gripping
	❑ Burning	❑ Tingling	❑ Other ________
Since it began, is your problem:	❑ Improving	❑ Getting Worse	❑ No Change
What makes the problem better?	❑ Nothing	❑ Lying Down	❑ Walking
	❑ Standing	❑ Sitting	❑ Movement
	❑ Exercise	❑ Inactivity/rest	❑ Other ________
What makes the problem worse?	❑ Nothing	❑ Lying Down	❑ Walking
	❑ Standing	❑ Sitting	❑ Movement
	❑ Exercise	❑ inactivity/rest	❑ Other ________
Can you perform your daily home activities?	❑ Yes	❑ Yes, only with help	❑ Not at all
Do you exercise?	❑ Yes, almost daily	❑ Yes, occasionally	❑ Not at all
Describe your job requirements:	❑ Mainly sitting	❑ Light Labor	❑ Heavy Labor
Can you perform your daily work activities?	❑ Yes, all activities	❑ Only some	❑ Not at all
Describe your stress level:	❑ None to mild	❑ Moderate	❑ High

What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)

____

Have you had X-rays, MRI or other tests for this condition? What tests and When? ____________

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



Patient Signature: ____________________ Date: ____________

Athens Chiropractic Clinic **Patient Health Questionnaire**

Patient Name____Patient ID#____________________

If you have *ever* had a listed symptom in the *past,* please check that symptom in the *Past Column.* If you are *presently* troubled by a particular symptom, check that symptom in the *Present column.* **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

Past	Present	Condition
		Neck Pain
		Shoulder Pain (R_____ L_____)
		Pain in Upper Arm or Elbow (R_____ L_____)
		Hand Pain (R_____ L_____
		Wrist Pain (R_____ L_____
		Upper Back Pain
		Low Back Pain
		Pain in Upper Leg or Hip (R_____ L_____)
		Pain in Lower Leg or Knee (R_____ L_____)
		Pain in Ankle or Foot (R_____ L_____)
		Jaw Pain
		Swelling, Stiffness of Joint(s)
		Fainting
		Visual Disturbances
		Convulsions
		Dizziness
		Headache
		Muscular Incoordination
		Tinnitus (Ear Noises)
		Rapid Heart Beat
		Chest Pains
		Loss of Appetite
		Anorexia
		Abnormal Weight
	Gain Loss	
		Excessive Thirst
		Chronic Cough
		Chronic Sinusitis
		General Fatigue
		Irregular Menstral Flow
		Profuse Menstral Flow
		Breast Soreness Lumps
		Endometriosis
		PMS
		Loss of Bladder Control
		Painful Urination
		Frequent Urination
		Abdominal Pain
		Constipation/irregular bowel habits
		Difficulty in Swallowing
		Heartburn/Indigestion
		Dermatitis/Eczema/Rash

Past	Present	Condition
		Depression
		Aortic Aneurysm
		High Blood Pressure
		Angina
		Heart Attack (date)________________________
		Stroke (date)____________________________
		Asthma
		Cancer, Explain__________________________
		Tumor, Explain__________________________
		Prostate Problems
		Blood Disorder
		Emphysema (chronic lung disorders)
		Arthritis
		Rheumatoid Arthritis
		Diabetes
		Epilepsy
		Ulcer
		Liver / Gallbladder problems
		Kidney Stones
		Hepatitis
		Bladder Infection
		Kidney Disorders (by condition)
		Colitis
		Irritable Colon
		HIV/AIDS
		Other___________________________________

If a family member has had any of the following, please mark the appropriate box:

Cancer	Epilepsy
Rheumatoid	Chronic Back Problems
Diabetes	Chronic Headaches
Heart Problems	Lupus
Lung Problems	Other ________________
High Blood Pressure______________________	

Do you have a permanent disability rating? **Yes** **No**

Location____

Date rating received_____________________________________

Rating Percentage_______________________________________

Present Weight_____________pounds

Height _______feet _______inches

Please check any of the following that apply to you.

Pregnancy, # births__________________

Birth Control Pills, type_______________

Medications (list if not listed elsewhere)

____

Hospitalizations/Surgical Procedures

Tobacco

Alcohol

Drug or Alcohol Dependence

Coffee/Tea/Caffinated Soft drinks:

cups/cans per day:______________

____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverages in the future.

Patient's Signature:______________________________________ Date: ______________________________

Athens Chiropractic Clinic **Patient Billing Information**

Patient's Name ______________________________ Date ____________

Treating Chiropractor: *Athens* *Patrignani* *Gutierrez*

Do you have Health Insurance? *Yes* *No*

Insurance Company Name ______________________________

Do you have Chiropractic Benefits on your plan? *Yes* *No* *Uncertain*

Subscriber's Name ______________________________ I.D. # ____________

Subscriber's Date of Birth ________________

Subscriber's Employer ______________________________

Relationship to Subscriber: *Self* *Spouse* *Dependent* *Other* ________________

I clearly understand and agree that I am responsible for payment of any and all services rendered to me at the time of my visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. Patients with group or individual insurance are responsible for any unpaid balance in the event their insurance either does not cover chiropractic or is terminated during treatment. I accept full responsibility for treatment and I release ATHENS CHIROPRACTIC CLINIC and it's doctors from any and all liability in the unlikely event that a problem occurs from my treatment. I, the undersigned, affirm that the above is true and correct, and consent to chiropractic care in this office.

Patient's Signature ______________________________ Date ____________

(Guardian Must sign for all patients 17 years old or younger)

(staff use only)

Received copy of Patient's Insurance Card? ***Yes*** ***No*** ***Staff Init.*** ________

Gave A.C.N. Paperwork? ***Yes*** ***No*** ***Staff Init.*** ________

A.C.N. Paperwork Completed? ***Yes*** ***No*** ***Staff Init.*** ________

DIAGNOSIS:

____

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PATIENT #____________ **ACCT. DATE**____________

Dr.: Athens Patrignani Gutierrez

Class: Cash PI WC PPO MC

Referral Type: Pt. RE Staff Fair Other