Confidential Patient Information

Name ________________________ Address ___________________________ City,St,Zip _____________________

Home Phone ______________________ Work Phone _____________________ Cell Phone ____________________

Date of Birth _______________Age _____ Emergency Contact Name & Phone __________________________________

Marital Status: M S D W E mail Address ____

Occupation___________________________ Employer ____

Work Address____ City,St,Zip _________________________

Spouse's Name ____ #of Children _________________________

Who may we thank for referring you to our office?____

Have you ever had Chiropractic before? Yes☐ ☐ No Date of last visit: ___________________

Have you ever had Acupuncture before? Yes☐ ☐ No Date of last visit: ___________________

Is this injury or illness related to: Employment☐ Auto Accident☐

Date:____ Location:____

Insurance Company:_______________________________ Phone:____

Do you have Health Insurance? Yes☐ No ☐ Do you have a Health Saving Account? Yes☐ No ☐

Primary Insurance Company______________________________ Phone_____________________________

Subscriber's Name:___________________________Date of Birth:_________ Employer: __________________________

Secondary Insurance Company_______________________________Phone ______________________________________

Subscriber's Name:___________________________Date of Birth:_________ Employer: __________________________

Charges are due when services are rendered……

Method of Payment ( ) Check ( ) Cash ( ) Credit Card

Why Chiropractic or Acupuncture Care? People receive Chiropractic or Acupuncture Care for a variety of reasons. Some go for **symptomatic relief** of pain or discomfort (**Relief Care**). Others are interested in having the **cause of the problem as well as the symptoms corrected** and relieved (**Corrective Care**). Your doctor will weigh your needs and desires when recommending your treatment program.

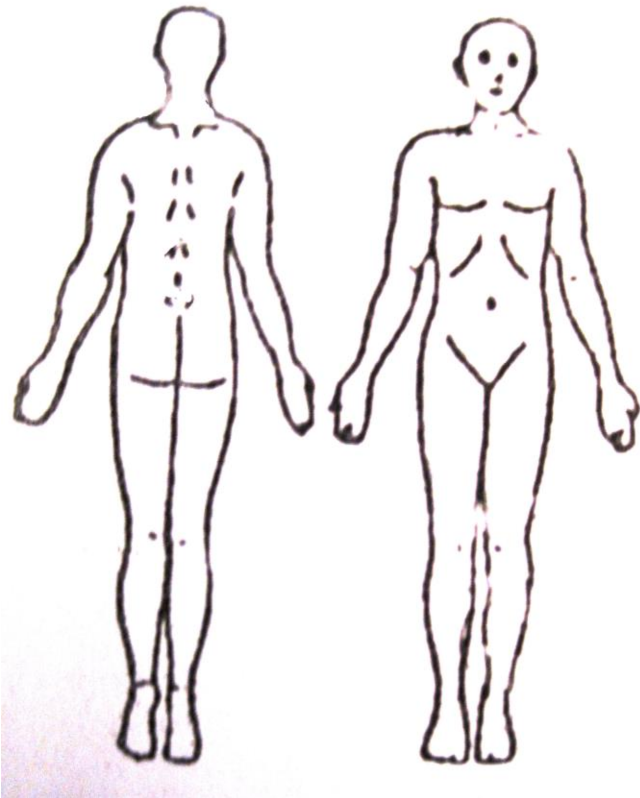
I authorize Popowich Chiropractic and Acupuncture Care to render necessary services to me and I am responsible for all charges incurred.

Patient/Guardian authorizing Care________________________ Signature__________________________ Date_______

Thank You For Allowing Us To Serve You!

If you have symptoms of pain (P), numbness (N),

tingling (T), burning (B) etc, please mark on diagram



Please list your present health concerns in order of severity:

1) ______________________________________

2) ______________________________________

3) ______________________________________

4) ______________________________________

5) ______________________________________

Please mark your current stress level:

--Mild----------------Moderate---------------Severe--

List other Chiropractic or Medical Doctors you have consulted for these conditions

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Check any of the following you have had in the last six months:

( ) Headaches	( ) Numbness
( ) Sinus Congestion/Allergies	( ) Frequent Nausea/Vomiting
( ) Vision Problems	( ) Abdominal Cramps
( ) Ear Aches	( ) Constipation
( ) Dizziness	( ) Diarrhea
( ) Heart Problems	( ) Poor/Excessive Appetite
( ) Lung Problems/Congestion	( ) Excessive Thirst
( ) Blood Pressure Problems	( ) Painful/Excessive Urination
( ) Ankle Swelling	( ) Discolored Urine
( ) Prostate/Sexual Dysfunction	( ) Diabetes
( ) Menstrual Cycle Dysfunction	( ) Cancer

Number of hours you sleep per night_____ Do you wake up between 2-3 am and feel wide awake? Y N

How many days per week do you exercise: ______ for how long _____

Is today visit for: Chiropractic Care _________Acupuncture Care _______ Wellness Care _____

Hormone Balance Testing________ Adrenal Stress Testing _________

Functional Medicine Evaluation_______ Laboratory testing______ Weight Loss _____

Females are you pregnant? ( ) Yes ( ) No ( ) Not Sure

Patient Name: ____ **Date:** ____________

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other ____________ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems
□ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other ___________
□ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _______________ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other ________________ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other ______________________ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _________ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _______________ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other __________ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other ______________________ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other ____________ □ None of the above

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Dr. John M. Popowich for services performed.
Charges are due when services are rendered. **Method of payment: □ Check □ Cash □ Credit Card**

Patient or Guardian Signature ___________________________________ Date_________________________