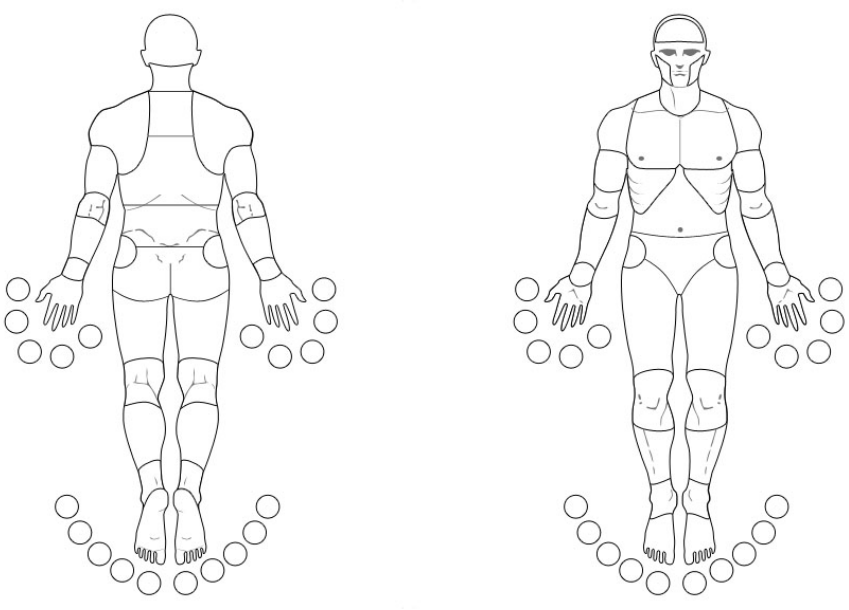
CURRENT COMPLAINTS

Patient's Name: _____ Date: _____

Please indicate the current complaints you are experiencing by marking the areas on the image below and providing details using the sections that follow.

1. Headaches
2. Neck
3. Upper back
4. Mid Back
5. Lower Back
6. Hip
7. Buttock
8. Shoulder
9. Arm
10. Elbow
11. Forearm
12. Wrist
13. Hand
14. Fingers
15. Leg
16. Knee
17. Calf
18. Shin
19. Ankle
20. Foot
21. Toes
22. Chest
23. Ribs
24. Abdomen
25. Pelvis/Groin



Area of Complaint: _____		
Location		❒ Left ❒ Right ❒ Both ❒ Center
Pain Ratings		❒ 0 ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10 (Excruciating)
Frequency		❒ Infrequent < 25% ❒ Occasional 25% to 50% ❒ Frequent 50% to 75% ❒ Constant > 75%
Pain Type		❒ No Pain ❒ Pain ❒ Numbness ❒ Tingling ❒ Muscle Spasms ❒ Burning
Severity		❒ Mild ❒ Mild to Moderate ❒ Moderate ❒ Moderate to Severe ❒ Severe
What makes it better?		❒ Medication ❒ Lying Down ❒ Standing ❒ Sitting ❒ Stretching ❒ Range of Motion ❒ Nothing
What makes it worse?		❒ Movements ❒ Bending ❒ Twisting ❒ Weight Bearing ❒ Movements ❒ Neck flexion ❒ Sneezing ❒ Sitting ❒ Standing ❒ Walking ❒ Chewing ❒ Yawning ❒ Opening mouth ❒ Closing mouth ❒ Range of motion ❒ pushing/pulling ❒ Lifting ❒ Watching T.V. ❒ Reading ❒ Working ❒ Driving ❒ Housework ❒ Bright lights ❒ Loud Noises
Does the pain radiate to any other locations?	Upper Body	❒ Head ❒ Forehead ❒ Back of head ❒ Right side of head ❒ Left side of head ❒ Neck ❒ Right Ear ❒ Left Ear ❒ Right Eye ❒ Left Eye ❒ Face ❒ Right Jaw ❒ Left Jaw ❒ Right Upper back ❒ Left Upper back ❒ Right Shoulder ❒ Left Shoulder ❒ Right Chest ❒ Left Chest ❒ Right Ribs ❒ Left Ribs
	Mid Body	❒ Right Mid back ❒ Left Mid back ❒ Right Lower back ❒ Left Lower back ❒ Right Hip ❒ Left Hip ❒ Right Buttock ❒ Left Buttock ❒ Groin ❒ Right Arm ❒ Left Arm ❒ Right forearm ❒ Left forearm ❒ Right hand ❒ Left hand ❒ Right fingers ❒ Left fingers
	Lower Body	❒ Right Thigh ❒ Left Thigh ❒ Right Knee ❒ Left Knee ❒ Right Calf ❒ Left Calf ❒ Right Toes ❒ Left Toes ❒ Right Foot ❒ Left Foot ❒ Right Toes ❒ Left Toes
Described as		❒ Aching ❒ Dull ❒ Sharp ❒ Stabbing ❒ Throbbing
At its worst		❒ Morning ❒ Afternoon ❒ Evening ❒ Night After Activities: ❒ Light ❒ Moderate
Associated with		❒ Dizziness ❒ Nausea ❒ Visual Problems ❒ Ringing/Buzzing ears ❒ Bright light ❒ Sensitivity ❒ Loss of balance
Comments		

Medical History Information

Last Name: First Name:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Widow
Email:		Birth date:	Age:	Sex:
Address:	City:		State:	
ZIP Code:	Social Security No.:	Primary Phone:		
Occupation:	Employer:		Employer phone:	

Medical Care Information

Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Do You Have a Family Chiropractor?: ☐ No ☐ Yes, Name of Chiropractor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Have you had surgeries in the last 5 Years: ☐ Yes ☐ No	If yes, Last Surgery Date:		
Reason for Surgery:			

Present illness /Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	☐
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐
Other:					

Family History of illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitus
Other:					

Type of Cancer: ☐ Breast ☐ Lung ☐ Other:

Social History:

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous

INSURANCE INFORMATION

Insurance Company: _____ Primary's Name: _____

Relationship to Patient: _____ Primary's DOB: _____

Primary's Employer: _____ Primary's SSN: _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or the patient named below, for whom I am legally responsible: (_____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine and all healthcare disciplines, the practice of chiropractic carries some risks to treatment; including, but not limited to: increased pain, spasms, sprains, fractures, disc injuries, strokes (CVA), dislocations, and even death. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are appropriate and in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

_____	_____	____/____/____
Print Patient Name	Patient Signature	Date
_____	_____	____/____/____
Parent/Guardian Name	Parent/Guardian Signature	Date

OFFICE USE

I have discussed the potential risks of treatment with the patient and they understood and have consented to begin care: _____ ____/____/____
Michael F. Radice, D.C. Date

CANCELLATION POLICY

Radice Family Chiropractic reserves the right to charge a **$25 fee** for missed appointments. If you are unable to make your scheduled appointment time, please call our office ***4 hours*** prior to appointment to re-schedule. Also, please understand you may experience a short wait for your appointment. We promise you'll receive the same personal attention and care during your appointment. Your patience is appreciated greatly. If you cannot wait, please feel free to reschedule with the front desk.

_____	____/____/____
Patient Signature	Date

APPOINTMENT REMINDERS

(Please Choose One)

____ I agree to receive text messages to this mobile phone number (_____) _____-_____ reminding me about my upcoming appointments with Radice Family Chiropractic. I understand that SMS reminders are optional and that message & data rates may apply.

____ I do not wish to receive reminders via text**.**

Signature _____

Date _____