Dr. Aaron Dixon
Chiropractic Physician

Whom may we thank for referring you to this office___________________________?

Today's Date:_______________________

PATIENT DEMOGRAPHICS

Name: ___________________________ Birth Date:______________ Age: _________ Sex: Male/Female

Address:________________________________ City:______________________ State:__________ Zip:_________

E-mail Address:_______________________________________ Social Security #:__________________

Home Phone: ____________________ Mobile Phone: _________________ Work Phone: ____________________

Do you have Insurance? Yes/ No, If Yes, Name of Insurance Company ____________________________________

Marital Status: Single/ Married Employer: ____________________ Occupation: ___________________________

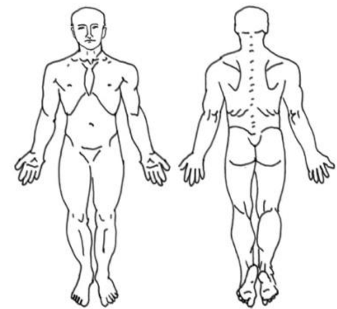
Spouse's Name __________________Spouse's Employer________________________

Number of children and Ages: ____

Name & Number of Emergency Contact: ________________________________Relationship:__________________

When doctors work together it benefits you. May be have permission to update your medical doctor regarding your care at this office?
YES or NO Name of doctor and clinic _________________________

HISTORY of COMPLAINT Please identify the condition(s) that brought you to this office and on a scale of 1 to 10 with 10 being the worst pain and one being no pain, rate your above complaints by circling the number:



Primary or chief complaint is______________________:0-1-2-3- 4-5-6-7-8-9-10

Second complaints is____________________________ :0-1-2-3- 4-5-6-7-8-9-10

Third complaint is ______________________________:0-1-2-3- 4-5-6-7-8-9-10

Fourth complaint is _____________________________:0-1-2-3- 4-5-6-7-8-9-10

Do you get headaches? Yes/ No If yes, how often? _____________________________

When did the problem(s) begin? ____

*PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms: R =Radiating B =Burning D =Dull A= Aching N =Numbness S =Sharp/ Stabbing T= Tingling

When is the problem at its worst? AM / PM / mid-day / late PM

How long does it last? It is constant / I experience it on and off during the day / goes throughout the week

What aggravates your pain? Sit/Stand/Walking/Bending/Lift/Twist/Push/Pull/Driving/Movements

What relieves your pain? Recumbence/Medication/ Movement/ Rest/ Adjustment/ Massage

How did the injury happen? ____________________________ What relieves your symptoms? ______________________________

What makes them feel worse?____

Condition(s) ever been treated by anyone in the past? No/Yes If yes, when:_____________________________

By whom?___________________ How long were you under care? ____

Name of Previous Chiropractor: ____

LIST RESTRICTED ACTIVITY: CURRENT ACTIVITY LEVEL: USUAL ACTIVITY LEVEL:

____

____

Dr. Aaron Dixon
Chiropractic Physician

Patients Name: ______________________________________ **Date:** ____________________

Is your problem the result of ANY type of accident? Yes / No If yes, date of accident: _____________________ Identify any other injury(s) to your spine, minor or major, that the doctor should know about: ____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? No / Yes If yes, how many times? __________

Episode? _____ How did the injury happen? _______________________________ ________________________

When was the last? ___________________ Other forms of treatment tried: No / Yes If yes, please state what type of

treatment: ______________________________ and who provided it? ________________ How long ago? ________________

What were the results? Favorable/ Unfavorable, please explain ____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:
____
____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the Past, **C** for Currently have and **N** for Never have had:

_Broken Bone/s _Dislocations _Heart Attack _Osteoarthritis _Tumors _Rheumatoid Arthritis _Diabetes _Stroke _Fracture _Disability _Cancer _Night Sweats _Difficulty Urinating _High Blood Pressure _Seizures _Indigestion Problems _Chest Pains/Tightness _Osteoporosis _Breathing Problems _Menstrual Difficulties _Dizziness _Frequent Colds _Depression _Loss of Memory _Gallbladder Problems _Ruptures _Weakness in Extremities _Numbness in Fingers _Numbness in Toes _Joint Pain/Swelling _Weight Loss/Gain

Any other serious conditions? :________________________________

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem

	HOW LONG AGO	TYPE OF CARE	BY WHOM
INJURIES: List:_____________________________			
SURGERIES List:____________________________			
CHILDHOOD DISEASES List:_________________________			
ADULT DISEASES List:______________________________			

SOCIAL HISTORY

1. Smoking: cigars/ pipe / cigarettes Daily/ Weekends/ Occasionally / Never
2. Alcoholic Beverage: consumption occurs Daily/ Weekends/ Occasionally / Never
3. Recreational Drug use: How often? Daily/ Weekends/ Occasionally / Never
4. How does your present problem affect the following: Hobbies -Recreational Activities- Exercise Regime:

____

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? No / Yes If yes who: grandmother /grandfather /mother / father / sister's / brother's / son(s) / daughter(s) - Have they ever been treated for their condition? No / Yes /I don't know

2. Any other hereditary conditions the doctor should be aware of No / Yes If yes, please explain

____

Dr. Aaron Dixon
Chiropractic Physician

Patients Name: ____ **Date:** ____________________

ACTIVITIES OF LIFE

Please circle how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:		EFFECT		
Carrying Groceries	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform
Sit to Stand	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform
Climbing Stairs	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform
Pet Care	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform
Driving	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform
Extended Computer Use	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform
Household Chores	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform
Lifting	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Reading/Concentration	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform
Dressing	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform
Shaving	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform
Sleep	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform
Extended Sitting	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform
Extended Standing	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform
Walking	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Washing/Bathing	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform
Sweeping/Vacuuming	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform
Dishes	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform
Laundry	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform
Yard work	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform
Exercise	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Sexual Activity	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Other: ____________	No *Effect*	Painful(can do)	Painful(limits)	Unable to Perform

Patients Signature: ____ Date: ______________________

Additional Information:

____

____

____

____

____

Dr. Aaron Dixon
Chiropractic Physician

Patients Name: ____ **Date: _____________________**

List Prescription & Non-Prescription medications you take:

_Pain Killers _ Muscle Relaxers _Blood pressure medication _Insulin

_Aspirin _Acetominophen _Ibuprofen

_Other/Over-the-counter____

<u>REGARDING: X-rays/lmaging Studies</u>

FEMALES ONLY please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

Are you pregnant? _________ Are you nursing? __________

The first day of my last menstrual cycle was on________________ date

By my signature below I am acknowledging that the above information is correct. I understand the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Signed: ____ Date: __________________

Witness: ____________________________________

I hereby authorize payment to be made directly to SYMMETRY CHIROPRACTIC AND WELLNESS CENTER, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies there of for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to SYMMETRY CHIROPRACTIC AND WELLNESS CENTER for any and all services I receive at this office.

____ __________________________________

Patient or Authorized Person's Signature Date Completed

____ __________________________________ Doctor's

Signature Date Form Reviewed

Dr. Aaron Dixon
Chiropractic Physician

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a Notice of Privacy Practices Pursuant To HIPAA and have been advised that a full copy of this office's HIPAA Compliance Manual is available upon request, and that this manual provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Print name of patient ____ Date ______________

Signature of patient ____ Date ______________

If patient is a minor or under a guardianship order as defined by State law:

By_____________________________________ Signature of Parent/Guardian (circle one)