ROSENBLUM CHIROPRACTIC, LLP

Patient Information Form

First Name:	Last Name:	Date Of Birth:
Home Phone:	Mobile Phone:	Work Phone:
@E-Mail:		
Street Address:	Apt/Suite #:	
City:	ZipCode:	State:

	Gender:	Preferred Language:
	♀ Female ♂ Male	❑ English ❑ Other _____

Race & Ethnicity:

❑ American Indian or Alaska Native ❑ Hispanic or Latino
❑ Asian ❑ Native Hawaiian or Other Pacific Islander
❑ Black or African American ❑ White ❑ Other

Marital Status:

❑ Single ❑ Married ❑ Other
❑ Divorced ❑ Widowed ❑ Separated

Primary Care Provider Name:	
Employer/Company Name:	Job Title/Position:

PLEASE TURN PAGE OVER 

Medical History

Are You A Smoker? ❑ Yes ❑ No	If Yes ➪ How Often? _____ /Day /Week
Do You Drink Alcohol? ❑ Yes ❑ No	If Yes ➪ How Often? _____ /Day /Week
Do You Exercise? ❑ Yes ❑ No	If Yes ➪ How Often? _____ /Day /Week
Height _____ft _____in Weight _____	

Have You Ever Been Hospitalized or had Surgery?	❑ Yes ❑ No
If Yes, Please List Dates/Details:	

List any severe injuries or accidents you may have had:

List all medication and suppliments you take:

Have you had chiropractic care before? ❑ Yes ❑ No When? _____

_____ Patient Signature

_____ Date

ROSENBLUM CHIROPRACTIC, LLP

NAME _____ DATE _____

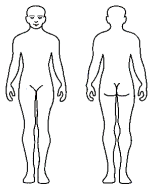
REASON FOR YOUR VISIT TODAY_____

_____

WHEN DID YOUR SYMPTOMS START? _____WHAT WAS THE CAUSE? _____

ARE YOUR SYMPTOMS THE RESULT OF AN ACCIDENT? □ YES □ NO (IF 'YES') □ AT WORK? □ AN AUTO ACCIDENT?

PLEASE MARK AN 'X' ON THE DRAWING WHERE YOU FEEL YOUR SYMPTOMS



ON A SCALE OF 1 TO 10 (10 BEING THE WORST PAIN EVER) WHAT IS THE LEVEL OF YOUR PAIN TODAY? _____

CHECK ANY OF THE FOLLOWING THAT DESCRIBE YOUR SYMPTOMS:

□ SHARP □ DULL ACHE □ NUMBNESS □ TINGLING □ STIFFNESS □ STABBING □BURNING □ THROBBING □ WEAKNESS

HOW ARE YOUR SYMPTOMS CHANGING? □ GETTING BETTER □ NOT CHANGING □ GETTING WORSE

HOW OFTEN DO YOU HAVE SYMPTOMS? □ CONSTANTLY □ FREQUENTLY □ OCCASIONALLY □ INTERMITTENTLY

WHICH ACTIVITIES MAKE YOUR SYMPTOMS WORSE? □ STANDING □ WALKING □ BENDING □ LYING DOWN □ LIFTING

WHAT MAKES YOUR SYMPTOMS BETTER? □ COLD □ HEAT □ LYING DOWN □ WALKING □ SITTING □ CHANGING POSITIONS

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? □ YES □ NO IF 'YES' WHEN?_____

WHO HAVE YOU SEEN FOR YOUR SYMPTOMS AND WHEN? _____

WHAT TREATMENT WAS GIVEN? _____

HAVE YOU HAD □ X-RAYS? □ CT SCAN? □ MRI? □ DATE & LOCATION OF TEST? _____

ARE YOU PREGNANT? □ YES □ NO □ N/A DUE DATE _____

_____ _____

PATIENT SIGNATURE DATE

Rosenblum Chiropractic, LLP
INSURANCE AUTHORIZATION

Name_____

Please present your insurance card and photo ID at the desk to be copied.

Name of your insurance company _____

Whose name is the Insurance under? _____

Patient's relationship to the insured: Self____ Spouse ____ Child_____ Other_____

Date of birth of insured _____ Insured's Employer _____

Insured's address (if different) _____

City_____ State _____ Zip_____

INSURANCE AUTHORIZATION & AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurer and myself. Furthermore, I understand that this office will prepare any necessary forms and reports to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient's (parent if minor) Signature _____ Date _____

GENERAL

- [ ] WNL
- [ ] Lethargy / Weakness
- [ ] Recurring Fever
- [ ] Recent weight loss or gain
- [ ] Dizziness
- [ ] Fever
- [ ] Chills
- [ ] Others:

HEENT

- [ ] WNL
- [ ] Headaches or migraines
- [ ] Eye or vision problems
- [ ] Eyeglasses or contact lenses
- [ ] Nose bleeds
- [ ] Eye surgery
- [ ] Cataracts
- [ ] Glaucoma
- [ ] Sore throat
- [ ] Hoarseness
- [ ] Swollen glands
- [ ] Nose congestion or sinus trouble
- [ ] Ear or hearing problems
- [ ] Dental problems
- [ ] Gum problems
- [ ] TMJ problems
- [ ] Postnasal drip
- [ ] Others:

SKIN / HAIR

- [ ] WNL
- [ ] Skin trouble or rashes
- [ ] Flushing
- [ ] Excessive acne
- [ ] Eczema
- [ ] Psoriasis
- [ ] Skin cancer
- [ ] Skin pigmentation issues
- [ ] Change in hair or nails
- [ ] Blood in stool
- [ ] Easy brusing
- [ ] Gum bleeding
- [ ] Others:

CARDIOVASCULAR

- [ ] WNL
- [ ] Chest pain or tightness
- [ ] Heart attack
- [ ] Shortness of breath
- [ ] Palpitations
- [ ] Swelling of feet or hands
- [ ] High blood pressure
- [ ] High cholesterol or triglycerides
- [ ] Heart murmur
- [ ] Blood clots
- [ ] Pacemaker
- [ ] Mitral valve prolapse
- [ ] Congenital heart defects
- [ ] Rheumatic fever
- [ ] Leg pain upon walking
- [ ] Varicose veins
- [ ] Dizziness
- [ ] Excessive brusing
- [ ] Coronary artery disease
- [ ] Others:

RESPIRATORY

- [ ] WNL
- [ ] Persistent cough
- [ ] Spitting up blood
- [ ] Asthma or wheezing
- [ ] Shortness of breath
- [ ] Exercise intolerance
- [ ] Sleep apnea
- [ ] Emphysema
- [ ] Snoring issues
- [ ] Tuberculosis
- [ ] Pneumonia
- [ ] Breathing
- [ ] Hay fever
- [ ] Others:

GASTROINTESTINAL

- [ ] WNL
- [ ] Loss of appetite
- [ ] Nausea or vomiting
- [ ] Diarrhea
- [ ] Constipation
- [ ] Abdominal pain
- [ ] Stomach ulcer
- [ ] Bloating/Cramping
- [ ] Heartburn
- [ ] Hemorrhoids
- [ ] Hepatitis
- [ ] Cirrhosis
- [ ] Difficulty swallowing
- [ ] Jaundice
- [ ] Liver disease
- [ ] Gallbladder problems
- [ ] Pancreatitis
- [ ] Change in bowel habits
- [ ] Black or bloody stool
- [ ] Colon cancer or colon polyps
- [ ] Food sensitivities
- [ ] Irritable bowel syndrome
- [ ] Crohn's disease
- [ ] Gastic reflux
- [ ] Collitis

NEUROLOGICAL

- [ ] WNL
- [ ] Frequent headaches
- [ ] Migraines
- [ ] Dizziness
- [ ] Fainting
- [ ] Memory loss
- [ ] Poor balance
- [ ] Numbness or tingling
- [ ] Pins and needles
- [ ] Epilepsy or seizures
- [ ] Stroke
- [ ] Tremors
- [ ] Head injury
- [ ] Anxiety and/or panic
- [ ] Depression
- [ ] Sleeping issues
- [ ] Weak muscles
- [ ] Loss of smell or taste
- [ ] Temporary loss of vision
- [ ] Difficulty concentrating
- [ ] Others:

MUSCULOSKELETAL

- [ ] WNL
- [ ] Arthritis
- [ ] Joint pain or swelling
- [ ] Neck pain
- [ ] Back pain
- [ ] Trauma
- [ ] Osteoporosis
- [ ] Scoliosis
- [ ] Cramping
- [ ] Fractures
- [ ] Implants, plates, pins or screws
- [ ] Hip disorders
- [ ] Knee injuries
- [ ] Foot / ankle pain
- [ ] Shoulder problems
- [ ] Elbow / wrist pain
- [ ] Poor posture
- [ ] Gout
- [ ] Others:

BLOOD / LYMPH

- [ ] WNL
- [ ] Anemia
- [ ] Bleeding
- [ ] Bruising
- [ ] Blood clots
- [ ] Past transfusions
- [ ] Leukemia
- [ ] Lymphoma
- [ ] HIV/AIDS
- [ ] Sickle cell
- [ ] Others:

ALLERGIES

- [ ] WNL
- [ ] Seasonal
- [ ] Medication
- [ ] Food
- [ ] Others:

PSYCHIATRIC

- [ ] WNL
- [ ] Alzheimer's Disease
- [ ] Insomnia
- [ ] Difficulty concentrating
- [ ] Memory loss/confusion
- [ ] Depression
- [ ] Anxiety
- [ ] Agitation/Irritability
- [ ] Suicidal thoughts
- [ ] Chemical dependency
- [ ] Others:

ENDOCRINE

- [ ] WNL
- [ ] Diabetes
- [ ] Thyroid problems
- [ ] Sweating
- [ ] Heat intolerant
- [ ] Cold intolerant
- [ ] Weight loss
- [ ] Weight gain
- [ ] Frequent urination
- [ ] Excessive thirst
- [ ] Change in appetite
- [ ] Hair changes
- [ ] Hyperthyroidism
- [ ] Hormonal or glandular concerns
- [ ] Hyperparathyroidism
- [ ] Testosterone deficiency
- [ ] Cushing's syndrome
- [ ] Steroid treatments
- [ ] Others:

URINARY

- [ ] WNL
- [ ] Painful or frequent urination
- [ ] Incontinence
- [ ] Hesitancy
- [ ] Urgency
- [ ] Blood in urine
- [ ] Kidney stones
- [ ] Urinary infections
- [ ] Genital or bladder or urinary complaints
- [ ] Others:

FEMALE

- [ ] WNL
- [ ] Painful sex
- [ ] Vaginal discharge
- [ ] Breast pain or lumps
- [ ] Hot flashes
- [ ] Menstrual irregularity
- [ ] Loss of libido
- [ ] Menopause
- [ ] Sexually transmitted disease
- [ ] Others: