# ROSENBLUM CHIROPRACTIC, LLP

Patient Information Form

MM DD YYYY

First Name: | Last Name: | Date Of Birth:

Home Phone: | Mobile Phone: | Work Phone:

@E-Mail:

Street Address: | Apt/Suite #:

City: | ZipCode: | State:

Gender:
♀ Female ♂ Male

Preferred Language:
❑ 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: | ▫Phone:

Street Address: | Apt/Suite #:

City: | ZipCode: | State:

Employer/Company Name: | Phone:

Street Address: | Apt/Suite #:

City: | ZipCode: | State:

Job Title/Position:

Currently Working:
❑ Yes ❑ No ➪ Date Stopped Working:

# Medical History

MM DD YYYY

## Lifestyle

| | |
|---|---|
| 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 |

| | |
|---|---|
| Have You Ever Been Hospitalized? ❑ Yes ❑ No | Have You Had Any Surgeries? ❑ Yes ❑ No |
| If Yes, Please List Dates/Details: | |

Do You Have Any Allergies? ❑ Yes ❑ No ➪ Do You Require Medical Treatment For Your Allergies? ❑ Yes ❑ No

If Yes, Please Provide Details:

Do You Take Any Medications? ❑ Yes ❑ No

Please List All Medications & Dosage (How Much & How Often?)

## Please Provide Any Other Medical Information You Feel The Doctor Needs To Know About

_____ 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 _____

## 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 _____**

# Rosenblum Chiropractic, LLP

NAME _____ DATE _____

REASON FOR YOUR VISIT TODAY_____

_____

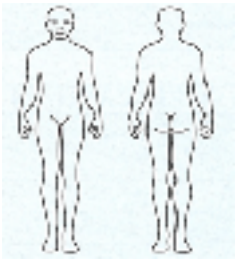
WHEN DID YOUR SYMPTOMS START? _____

WHAT WAS THE CAUSE? _____

ARE YOUR SYMPTOMS THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO

IF 'YES' WAS IT ☐ 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

THE PAIN INTERFERES WITH MY: ☐ WORK ☐ SLEEP ☐ DAILY ROUTINE ☐ SOCIAL LIFE

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS?

☐ CONSTANTLY ☐ FREQUENTLY ☐ OCCASIONALLY ☐ INTERMITTENTLY

WHICH ACTIVITIES MAKE YOUR SYMPTOMS WORSE?

☐ STANDING ☐ WALKING ☐ BENDING ☐ LYING DOWN
☐ LIFTING ☐ OTHER _____

WHAT MAKES YOUR SYMPTOMS BETTER?

☐ COLD ☐ HEAT ☐ LYING DOWN ☐ WALKING ☐ SITTING
☐ CHANGING POSITIONS ☐ STRETCHING

TURN PAGE OVER

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 _____

HAVE YOU HAD CHIROPRACTIC CARE BEFORE? ☐ YES ☐ NO WHEN? _____

HEIGHT_____ WEIGHT_____

_____ _____

PATIENT SIGNATURE DATE

## REVIEW OF SYMPTOMS

### GENERAL

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

### HEENT

- [ ] WNL
- [ ] Headaches
- [ ] Visual changes
- [ ] Sinus problems
- [ ] Nose bleeds
- [ ] Hearing loss
- [ ] Ear pain
- [ ] Ringing in ears
- [ ] Sore throat
- [ ] Hoarseness
- [ ] Swollen glands
- [ ] Bleeding gums
- [ ] Other:

### SKIN / HAIR

- [ ] WNL
- [ ] Rashes
- [ ] Itching
- [ ] Lesions
- [ ] Hives
- [ ] Psoriasis
- [ ] Mole changes
- [ ] Change in skin color
- [ ] Change in hair
- [ ] Nail problems
- [ ] Other:

### CARDIOVASCULAR

- [ ] WNL
- [ ] Chest pain
- [ ] Heart attack
- [ ] Shortness of breath
- [ ] Palpitations
- [ ] Swelling of feet or hands
- [ ] High blood pressure
- [ ] High cholesterol
- [ ] Heart murmur
- [ ] Blood clots
- [ ] Pacemaker
- [ ] Mitral valve prolapse
- [ ] Other:

### RESPIRATORY

- [ ] WNL
- [ ] Chronic or frequent cough
- [ ] Spitting up blood
- [ ] Asthma or wheezing
- [ ] Shortness of breath
- [ ] Exercise intolerance
- [ ] Sleep apnea
- [ ] Emphysema
- [ ] Other:

### GASTROINTESTINAL

- [ ] WNL
- [ ] Loss of appetite
- [ ] Nausea or vomiting
- [ ] Diarrhea
- [ ] Constipation
- [ ] Abdominal pain
- [ ] Stomach ulcer
- [ ] Bloating/Cramping
- [ ] Heartburn
- [ ] Rectal bleeding
- [ ] Hemorrhoids
- [ ] Hepatitis
- [ ] Cirrhosis
- [ ] Other:

### NEUROLOGICAL

- [ ] WNL
- [ ] Frequent headaches
- [ ] Migraines
- [ ] Dizziness
- [ ] Fainting
- [ ] Memory loss
- [ ] Poor balance
- [ ] Numbness or tingling
- [ ] Pins and needles
- [ ] Limb weakness
- [ ] Seizures
- [ ] Stroke
- [ ] Tremors
- [ ] Head injury
- [ ] Other:

### MUSCULOSKELETAL

- [ ] WNL
- [ ] Arthritis
- [ ] Muscle pain
- [ ] Muscle cramps
- [ ] Muscle stiffness
- [ ] Joint pain or swelling
- [ ] Neck pain
- [ ] Back pain
- [ ] Trauma
- [ ] Other:

## BLOOD / LYMPH

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

## ALLERGIES

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

## PSYCHIATRIC

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

## ENDOCRINE

- [ ] WNL
- [ ] Diabetes
- [ ] Thyroid disease
- [ ] Sweating
- [ ] Heat intolerant
- [ ] Cold intolerant
- [ ] Weight loss
- [ ] Weight gain
- [ ] Frequent urination
- [ ] Excessive thirst
- [ ] Change in appetite
- [ ] Hair changes
- [ ] Other:

## URINARY

- [ ] WNL
- [ ] Frequent urination
- [ ] Burning or painful urination
- [ ] Incontinence
- [ ] Hesitancy
- [ ] Urgency
- [ ] Blood in urine
- [ ] Other:

## FEMALE

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

## MALE

- [ ] WNL
- [ ] Dribbling
- [ ] Loss of libido
- [ ] Erectile dysfunction
- [ ] Sexually transmitted disease
- [ ] Testicular pain or lumps
- [ ] Prostate disease
- [ ] Penile discharge
- [ ] Other: