Bellevue Chiropractic Center

Kirk W. Jones, D.C.
Chiropractor

Confidential Patient Information

REFERRED BY: ( ) Insurance Co., ( ) Internet, ( ) Other: _____ (Please check)

NAME: _____ **DATE**: _____
BIRTH DATE _____/_____/_____ **AGE:** _____ **SOCIAL SECURITY #** _____
CURRENT ADDRESS: _____ **APT #** _____
CITY: _____ **ST**: _____ **ZIP**: _____
PHONE: Cell ( ) _____ Home ( ) _____ Work ( ) _____
EMAIL ADDRESS: _____
Employer Name: _____ City/State/Zip: _____
Occupation: _____ Emergency Contact/Phone: _____
Name of Spouse: _____ Spouse Birth Date: _____ Spouse Phone: ( ) _____

HEALTH INFORMATION

Chief Complaint: _____
_____
How long have you had this condition? _____
Have you had similar conditions in the past? _____ If yes When_____
Does this condition affect your work? Yes/No Does this condition affect your family or social life? Yes/No
What aggravates this condition? _____
What helps your symptoms? _____
Have you had any surgery, falls or accidents: Yes/No When? _____
Please describe_____
Date of last physical examination: _____ Date of last spinal x-ray_____
Have you had previous chiropractic care? Yes/ No When _____ Where _____
Primary Care Physician: _____ Phone: ( ) _____
Number of children and ages: _____ Number of pregnancies: _____
Known Allergies: _____ Medications: _____

CURRENT MEDICAL COMPLAINTS

Do you experience pain every day? ( ) Yes ( ) No Does your pain wake you up during the night? ( ) Yes ( ) No
Does your pain worsen during menses? ( ) Yes ( ) No

Presently pain is increased when you: **Sit?** ( ) Yes ( ) No **Climb?** ( ) Yes ( ) No **Stand?** ( ) Yes ( ) No
Crouch? ( ) Yes ( ) No **Rise from the chair?** ( ) Yes ( ) No **Kneel?** ( ) Yes ( ) No **Walk?** ( ) Yes ( ) No
Bend? ( ) Yes ( ) No **Push?** ( ) Yes ( ) No **Pull?** ( ) Yes ( ) No **Rise up from bending?** ( ) Yes ( ) No
Lift? ( ) Yes ( ) No **Crawl?** ( ) Yes ( ) No **Repeated lifting?** ( ) Yes ( ) No
Reach <u>above</u> shoulder level? ( ) Yes ( ) No **Reach <u>below</u> shoulder level?** ( ) Yes ( ) No

What do you do to relieve the pain? _____
If you have been treated by others for this condition, please list in order of most recent:
1) _____ Date: _____ City: _____
2) _____ Date: _____ City: _____
3) _____ Date: _____ City: _____

During the past two months has your condition: ( ) Improved ( ) Unchanged ( ) Worsened

121 Belle Forest Circle, Nashville, TN 37221-2157
(615) 662-0001 – Fax: (615) 662-0000

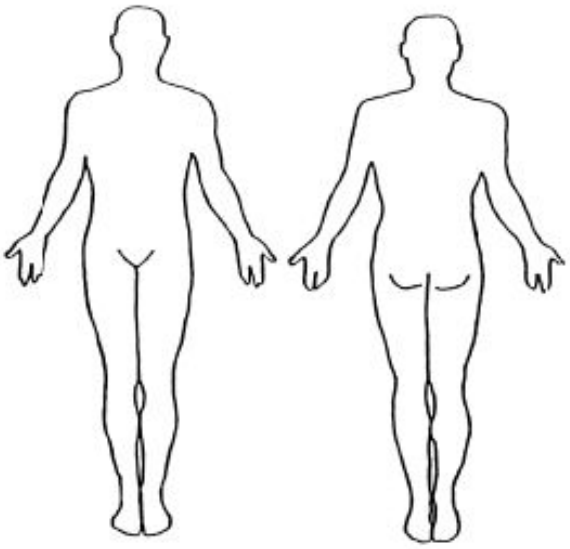
Describe how your condition affects at-home responsibilities, recreational activities and lifestyle:

_____

Do you perform daily neck/back exercises: ❍ Yes ❍ No

INSURANCE INFORMATION

Medical Insurance Co.: _____ ID #: _____ Group #: _____
Is this condition due to: A work injury ❍ Yes ❍ No - An automobile accident ❍ Yes ❍ No



Please indicate the appropriate location of pain and the symbol tly experiencing:

SHARP AND STABBING ††††
DULL AND ACHY **XXXX**
PINS AND NEEDLES **0000**
NUMBNESS //////

Is your pain constant: □ Yes □ No

Severity of your pain on a scale of 1-10
1 2 3 4 5 6 7 8 9 10

Please describe other medical complaints:
_____
_____
_____
_____

DO YOU SUFFER FROM:	YES / NO	DO YOU SUFFER FROM:	YES / NO
Headache	❑ ❑	Lung or Bronchial Disorder	❑ ❑
Neck Pain	❑ ❑	Digestive Disorder	❑ ❑
Arm/Shoulder Pain	❑ ❑	Constipation	❑ ❑
Back Pain	❑ ❑	Loose Stool	❑ ❑
Hip or Leg Pain	❑ ❑	Diabetes	❑ ❑
Chest Pain	❑ ❑	Swollen Joints	❑ ❑
Abdominal Pain	❑ ❑	Insomnia	❑ ❑
Sinus Trouble	❑ ❑	Dizziness	❑ ❑
Heart Trouble	❑ ❑	Numbness	❑ ❑
Palpitation	❑ ❑	Nervousness	❑ ❑
Circulatory	❑ ❑	Depression	❑ ❑
High or Low Blood Pressure	❑ ❑	General Fatigue	❑ ❑
Female Problems	❑ ❑	Morning Fatigue	❑ ❑
Prostate Disorder	❑ ❑	Anemia	❑ ❑
Kidney Problems	❑ ❑	Poor Memory	❑ ❑
Bladder Problems	❑ ❑	Hot Flashes	❑ ❑
Cancer	❑ ❑		❑ ❑

I understand I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. I hereby assign my major medical insurance benefits, including Medicare, private insurance and other health plans to Bellevue Chiropractic Center. Any overpayment will be promptly refunded. I also authorize Bellevue Chiropractic Center to release any information required to secure payment. If balance becomes delinquent and suit is filed, I agree to pay all collection costs, court costs, and attorney's fees in addition to the above fee. Accounts over 90 days delinquent may be subject to a monthly billing fee of $10.00.

Patient/Guardian Signature _____ Date _____

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