# Simmons Specific Chiropractic P.C.

****Please fill out in black ink.** Red and yellow areas are required. Dr. Signature: _____

Date: _____

Prefix: Ms. / Miss. / Mrs. / Mr.

First Name: _____

Middle Name: _____

Last Name: _____Jr. / Sr.

Nick Name or preferred to be called_____

Address: _____

_____

City: _____

State: _____ Zip Code: _____

**Please check preferred contact information**

☐ Home Phone: (  ) _____

☐ Work Phone: (  ) _____

☐ Cell Phone: (  ) _____

☐ E-Mail: _____

☐ No E-mail

Number of Children in Household: _____

Born: _____ / _____ / _____ AGE: _____

SSN: _____ / _____ /_____

Gender: M / F

Married: S / M / W / D

Ethnicity: Non-Hispanic Hispanic

Race: Caucasian African American

Other _____

Preferred Language: _____

Occupation: _____

Employer: _____

Employment: Full Time / Part Time

Unemployed / Self-Employed / Retired

Military / Student

**Currently Pregnant: Y / N**

**Week: _____ Due Date: _____**

Name and Number of Emergency Contact: _____

Relationship: _____

## Insurance Information

**(In addition to giving us your card, please fill out the following information.)**

*Primary Insurance:* _____ Insured's Name: _____

Date of Birth of Insured: ____ /____ /____ Insured Social Security #: ____ /____ /____

*Secondary Insurance:* _____ Insured's Name: _____

Date of Birth of Insured: ____ /____ /____ Insured's Social Security #: ____ /____ /____

☐ *No Insurance, will be paying out of pocket*

## Current Health Condition

Current Complaint(s): _____

Check all that apply:

(  ) Neck Pain/Discomfort

(  ) Mid-Back Pain/Discomfort

(  ) Shoulder Pain/Discomfort

(  ) Lower Back, Pelvic, and/or Sacral Pain/Discomfort

Has this condition occurred before? Y / N

Other doctors seen for this condition: Y / N Who? _____

Type of Treatment: _____ Results: _____

Is this condition: (  ) Auto Related (  ) Work Related (  ) Home Related

Put your healthcare needs in our hands!

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**Activities of Daily Living (ADL's)**
Please indicate below any ADL's you are **currently having difficulty** with.

( ) Lifting Children
( ) Putting Socks and Shoes On
( ) Bathing/Showering
( ) Getting Dressed
( ) Use Cane or Walker
( ) Washing Dishes
( ) Brushing Teeth
( ) Getting In and Out of Vehicle
( ) Care for Disabled Spouse, Parent or Loved One
( ) Lifting Objects
( ) Working
( ) Walking/Running
( ) Standing Up/Sitting Down
( ) Vacuuming and cleaning
( ) Reading/Concentrating
( ) Other _____

**Work duties**
Please indicate below what is required of you with respect to your career.

( ) Drive Long periods
( ) Lifting
( ) Twisting
( ) Squatting/Crouching
( ) Kneeling
( ) Using Tools
( ) Lifting and moving Patients
( ) Standing Long Periods
( ) Computer Work
( ) Fly Often / Travel
( ) Crawling
( ) Pushing/Pulling
( ) Getting in & Moving in Cramped Positions
( ) Sitting Long Periods
( ) Maintaining an Awkward Position
( ) Climbing
( ) Using Work Equipment
( ) Reaching Above Shoulders
( ) Repetitive Movements with Hands

**Please indicate below how the pain/complaint has affected your work: _____**
_____

**Social History**
Please indicate below how the pain/complaint has affected your social habits/activities.

How has your current complaint/pain **affected** your sport's participation? _____
_____

How has your current complaint/pain **affected** your exercise program? _____
_____

Check which habit(s) you are currently involved in:

***Smoke*** ( ) ***Alcohol*** ( ) ***Drug use***

( ) 0 cigarettes per day (non-smoker or less than 100 in lifetime)
( ) 0 cigarettes per day (previous smoker)
( ) Few (1-3) cigarettes per day
( ) 1-2 packs per day
( ) 2 or more packs per day
( ) Current Tobacco user
( ) Not a current tobacco user

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**Symptoms**

**Please check any of the following symptoms you have or have had.**

| | | |
|---|---|---|
| ( ) Headaches | ( ) Asthma/Wheezing | ( ) Earache |
| ( ) Dizziness | ( ) Shortness of Breath | ( ) Blurred Vision |
| ( ) Loss of Sleep | ( ) Fatigue | ( ) Numbness / Pain in |
| ( ) History of Cancer | ( ) Bladder Problems | Arms, Hands, or Legs |
| ( ) Stress | ( ) High Blood Pressure | ( ) Arthritis |
| ( ) Low Blood Pressure | ( ) Diarrhea | ( ) Chest Pain |
| ( ) Sciatica | ( ) Swollen Joints | ( ) Hernia |
| ( ) Previous Heart Attack | ( ) Foot/Ankle Trouble | ( ) Hip Pain |
| ( ) Spinal Curvature | ( ) Colitis | ( ) Faulty Posture |
| ( ) Numbness | ( ) Paralysis | ( ) Bed-Wetting |
| ( ) Cold/Tingling Extremities | | ( ) Other _____ |

On-going Health problems: None Known _____

_____

**Past Health History**

Life changing events, hospitalizations or surgeries: other; _____

| | | | |
|---|---|---|---|
| ( ) Appendectomy | ( ) Tonsillectomy | ( ) Hernia | ( ) Chemotherapy |
| ( ) Broken Bones | ( ) Back | ( ) Dental / Facial Surgery | ( ) Chelation Therapy |
| ( ) Neck | ( ) Heart | ( ) Gall Bladder | ( ) Physical Therapy |

Date of Last Car Accident: _____Recent Slip or Fall (Within last 12 months): _____

( ) Previous Chiropractic Care ( ) No previous Chiropractic Care

Doctor's Name and Date of Last Visit: _____

**Medication(s) you are now taking:**

| Name | Dosage | Reason/Symptom |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Allergies to any medications? Unknown _____

List any **Pain Killers** you are currently taking: _____

Do you wear a shoe lift? Y / N Do you wear a heel lift? Y / N

Put your healthcare needs in our hands!

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PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

A. I authorize release of any Medical information necessary to process my claims and request payment of insurance benefits either to myself or to the party who accepts assignment below. I authorize payment of any medical benefits directly to Simmons Specific Chiropractic P.C. for any services rendered to me. I am signing saying I am financially responsible if my health insurance does not pay or determine the care "not medically necessary" for my services rendered. In addition, by signing this allows Simmons Specific Chiropractic P.C. to have my radiographs/ digital images interpreted by a D.A.C.B.R., a radiologist certified by the American Chiropractic Board of Radiology.

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Signature: _____ Date: _____

Under 18 years of age:
Parent or Guardian's
**Consent to evaluate and adjust a minor child**

I, _____ being the parent of legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grand permission for my child to receive chiropractic care.

Signature Authorizing Care: _____ Date: _____

**FEMALE ONLY Pregnancy Release**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an X-ray evaluation. I have been advised that X-ray can be hazardous to an unborn child. Date of last menstrual cycle._____.

_____ Date:_____
(Signature)

## Medicare patients only

**Signature of Beneficiary: _____ Medicare Number: _____**
I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished by Simmons Specific Chiropractic P.C, including physician services. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits for related services.

******If Medigap**

**Signature of Beneficiary: _____Medicare Number:_____**

**Medigap Policy Number: _____**
I request payment of authorized Medigap benefits be made either to me or on my behalf to Simmons Specific Chiropractic P.C for any services furnished to be by that physician. I authorize any holder of medical information about me to be released to Simmons Specific Chiropractic P.C. and any information needed to determine these benefits or the benefits payable for related services.

Put your healthcare needs in our hands!