Satterwhite Chiropractic of Oxford

Patient Data **Date** ____

Title: (Check one) ☐ Mr. ☐ Mrs. ☐Ms. ☐ Miss ☐ Dr. ☐ Other _______

First Name ___________________ **Middle Initial** ____ **Last Name** __________________________

Address Line 1 ____

Address Line 2 ____

City _______________________________ **State** ___________________ **Zip Code** ______________

Home Phone (_____) ________-___________ **Work Phone** (_____) _________-_____________

Cell Phone (_____) ________-____________ **Email** ___________________________________

Date of Birth ______/______/_______ Age: ______ **Sex:** ☐ Male ☐ Female

Social Security Number: ______-_____-______ **Marital Status:** ☐ Single ☐ Married ☐ Other

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other_____

Spouse Data ____

First Name ___________________ **Middle Initial** _____ **Last Name** _________________________

Home Phone (_____) _______-___________ **Work Phone** (_____) _________-_____________

Employer Data

Name ____

Your Occupation _________________________ **Your Job Description** _____________________

Address ____

City ________________________________ **State** _________________ **Zip Code** ______________

Emergency Contact

Contact Name ____________________________ **Relationship to Patient** ___________________

Contact Home Phone (_____) _______-________ **Cell Phone** (_____) ________-______________

Doctor's Signature ____

Patient Name____**Date**__________________

Medical Conditions: (Check all that apply to you)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke

☐ Other ______________ ☐ Have you ever had any serious falls, accidents, strains, hospitalizations, surgeries, length illnesses? ☐ **YES** ☐ **NO** If so please describe: ________________________________
____

Surgeries: (Check all that apply to you)

☐ Appendectomy	☐ Cardiovascular procedure	☐Cervical spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic spine	☐ Knee
☐ Carpal Tunnel	☐ Gastro-intestinal	☐ Uro-genital	☐ Hernia
☐ Other ______________			

Allergies: (Check all that apply to you)

☐ Eggs	☐ Fish and Shellfish	☐ Milk or Lactose	☐ Peanuts
☐ Soy	☐ Sulfites	☐ Wheat/Glutens	☐ Other _________

Social History: (Check all that apply to you)

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Chew Tobacco:	☐ occasional	☐ often	☐ never
Cigarettes:	☐<1 pack/day	☐ >1 pack/day	☐ never
Wear Seat Belts:	☐ occasional	☐ always	☐ never
Other ________________			

Family History: (Check all that apply)

Arthritis:	☐ Parent	☐ Sibling
Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling
Heart Disease	☐ Parent	☐ Sibling
Hypertension	☐ Parent	☐ Sibling
Stroke	☐ Parent	☐ Sibling
Thyroid	☐ Parent	☐ Sibling
Other _________________		

Mother: Alive Deceased Age: ______
Cause of Death: ________________________
Health Problems: ____________________________

Father:: Alive Deceased Age: ______
Cause of Death: ________________________
Health Problems: ____________________________

Occupational Activities: (Check one that best describes your job description)

☐ Administration	☐ Business Owner	☐ Clerical/Secretary	☐ Computer User
☐ Heavy Equipment operator	☐ Daycare/Childcare	☐ Construction	☐ Health Care
☐ Food Service Industry	☐ Medium Manual Labor	☐ Manufacturing	☐ Home Services
☐ Heavy Manual Labor	☐ Light Manual Labor	☐ Executive/Legal	☐ Housekeeper
☐ Other ________________			

Doctor's Signature ____

Patient Name____**Date**_________________

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson’s				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

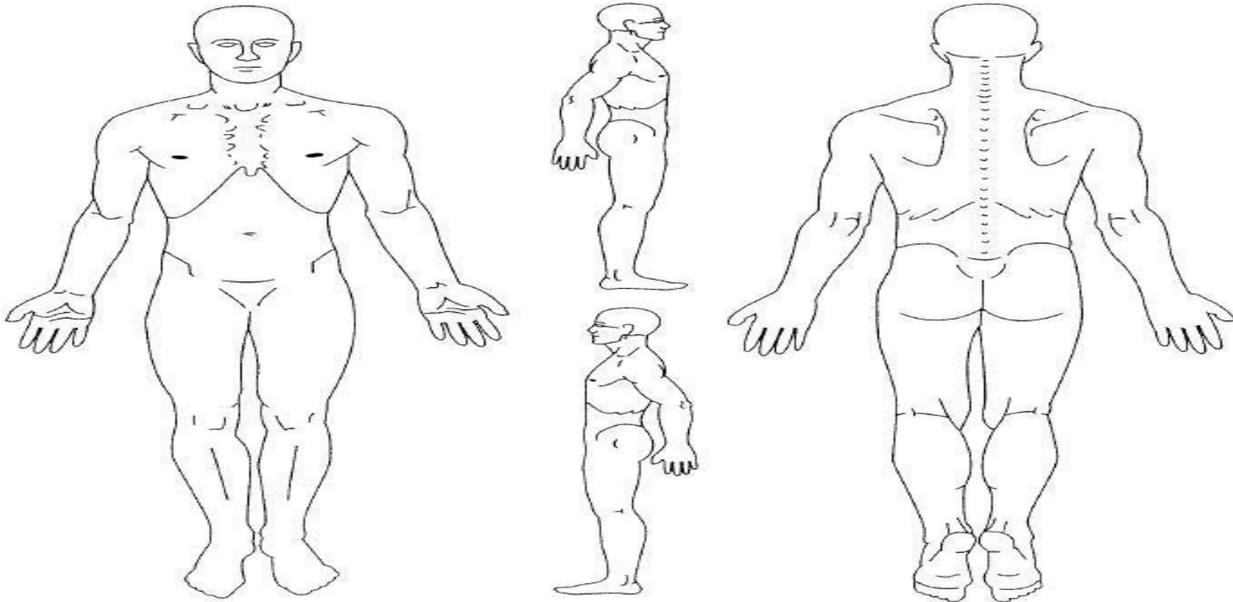
Please list all current medications being taken ____
____
____

Doctor’s Signature ______________________________________

Patient Name____Date__________________________

Are you pregnant? Yes_____ No ______N/A______

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms: N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache
Pain Level: 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)



Describe your (complaints) symptoms in order of severity, with worse (complaints) symptom being #1: ____
____

When did your symptoms begin? Month______________ Day____________Year _______________

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐Work related Accident ☐ Other_____

Please describe what makes your symptoms worse: ____

Please describe what makes your symptoms better: ____

What doctors have you seen for this condition(s): ____

What medications are you taking for this condition: ____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Intermittently (26-50% of the day) ☐ Occasionally (0-25% of the day)

What describes the nature of your symptoms?

☐ Sharp ☐ Dull ache ☐ Numb ☐ Shooting
☐ Burning ☐ Tingling ☐ Stabbing ☐ Other ______

Doctor's Signature ____

Patient Name ______________________________ **Date** ____________

How are your symptoms changing?
☐ Getting better ☐ Not changing ☐ Getting worse

Employment, ADL, and Recreation Information

Outcomes Assessment Tool Used ______________________________ **Score** ____________

Description of Work: ______________________________

Condition's Effect On Job Performance: ☐ **No Effect** ☐ **Mild** (painful can do) ☐ **Mod** (painful limited ability)
☐ **Mod/Sev** (limited duty) ☐ **Sev** (no limited duty) ☐ **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Activity				
Bending:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Care –Infirm Family:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Carrying Groceries:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Change Posn–Sit-Stand:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Climb Stairs:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Driving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Extended Computer Use:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Feeding:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Household Chores:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Kneeling:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lift Children:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Pet Care:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Reading (Concentration):	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Bathing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Dressing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Shaving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sexual Activities:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sleep:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Sitting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Standing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Walking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Yard Work:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

Activity				
____________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
____________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
____________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform

Doctor's Signature ______________________________

Patient Name____ **Date**____________________

Payment/Insurance Information:

Who is responsible for your bill? ☐ Self ☐ Health Insurance ☐ Spouse ☐ Worker's Comp
☐ Auto Insur. ☐ Medicare ☐ Medicaid ☐ Other ____________________________________

Personal Health Insurance Carrier: ________________________ Insur. Card ID # ____________________

Policy Holder's Name: __________________________________ Group # __________________________

Policy Holder's Date of Birth ______ / _____ / ______ Primary Care Physician __________________

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? ☐Yes ☐No Date: ____/____/____ Time: ______am / pm

Have you reported the auto accident with your car insurance?: ☐Yes ☐No

Name of Carrier: ____

Do you have a claim number: ☐Yes ☐No Claim Number: _____________________________

Do you have an attorney: YES NO If yes, Attorney's Name: ______________________________________

Phone Number: ______________________________________

Consent to Treat a Minor: (Minor's Printed Name) ______________________________

Guardian / Spouse's Signature Authorizing Care _______________________________
Date__________________

SIGNATURE OF PHYSICIAN: __________________________________**Date:** ____________________