Dr. Jane Torrie, Chiropractor

Name_____ Date_____

Street Address_____ City _____ _____

State_____ Zip_____ Email Address _____ SSN _____

H. Phone _____ Cell Phone_____ Date of Birth_____ Age_____

Referred by_____ Occupation_____ Employer_____

Marital Status S M D W Spouse Name_____

Number of Children/Ages_____ Spouse's Occupation_____

Have you ever received Chiropractic Care? Yes No _____

Other than Medicare (and associated supplemental programs), we are not in network with any insurance companies. We keep our rates low to make care affordable on a self pay basis.

Do you have Medicare? Y N Do you have a supplemental insurance Y N We will need to make a photocopy of the cards and your Driver's License.

About Your Health

Please circle for each of the following:			Patient Comment	Chiropractor's Comments
1. Health history:				
Childhood illnesses?	Y	N	_____	_____
Ear infections/ Colic/ Asthma?	Y	N	_____	_____
Attention Deficit?	Y	N	_____	_____
Accidents?	Y	N	_____	_____
Surgery?	Y	N	_____	_____
Did you fall down stairs?	Y	N	_____	_____
Chair pulled out when sat down?	Y	N	_____	_____
Were you yanked by your arm?	Y	N	_____	_____
Did you have other traumas?	Y	N	_____	_____
Did you ever break any bones?	Y	N	_____	_____
2. Current Health Habits:				
Did/do you smoke?	Y	N	_____	_____
Did/do you drink alcohol?	Y	N	_____	_____
Did/do you use caffeine?	Y	N	_____	_____
Diet, do you eat healthy foods?	Y	N	_____	_____
How much water do you drink?			_____	_____

Have you been in accidents/trauma?	Y	N	_____	_____
Have you had surgery?	Y	N	_____	_____
Teeth problems?	Y	N	_____	_____
Eye problems?	Y	N	_____	_____
Hearing problems?	Y	N	_____	_____
Exercise regularly?	Y	N	_____	_____
Do you sleep well?	Y	N	_____	_____
Did/do you have occupational stress?	Y	N	_____	_____
Physical stress?	Y	N	_____	_____
Emotional/Mental stress?	Y	N	_____	_____
Hobbies/Sports injuries?	Y	N	_____	_____
Sleeping posture? O side O stomach O back			_____	_____

Symptoms and Present State of Health

Previous years of unnoticed and or unattended damage to the nervous system and spine may show up as acute or chronic symptoms.

Present Complaint/Reason for Seeking Care in this Office:

_____

Pain or Problem started on_____

Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other_____

Does this pain shoot, radiate, or travel in your body? ___ yes ____ no

Where?_____

Are you experiencing numbness or tingling in any area of your body? ? ___ yes ____ no

Where?_____

What activities aggravate your condition or pain?

_____

_____

What activities lessen your condition or pain?

_____

_____

Is this condition worse during certain times of the day?_____

Is this condition interfering with work?_____ Sleep?_ ____ Routine?_____ Other?_____

Is this condition progressively getting worse? _____

Please Circle how you feel today:

(No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Other Doctors seen for this condition _____

Any home remedies? _____

Please mark any of the following that you have now or have experienced:

Other Symptoms:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure

O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Menstrual Cramps
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste

What other conditions do you have? _____ _____

Have you been under drug and medical care?_____ _____

What Medications are you taking?_____ _____

How long?_____

Have you had surgery?_____ What?_____ When?_____

Have you experienced side effects from the drugs and surgery? _____

_____

Females Only – Date last Menstrual Period began on_____ Are you possibly Pregnant?_____

Male only – Prostate issues _____

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	O	O	O	O	O _____
Mother's side	O	O	O	O	O _____

About Your Care

Chiropractic patients often experience several stages of treatment. The first is initial intensive care, which corrects the most recent layer of spinal and neurological damage. This care often reduces or eliminates the symptoms. Then reconstructive care begins, which corrects the years of damage that occurred when there were few symptoms. Finally, Chiropractic offers a genuine approach to Wellness Care. If you have questions about any of these options please ask. Then you'll be able to begin a course of care that fits your goals.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to do whatever is necessary in accordance with this state's statues, to provide me with chiropractic care.

I understand that I am financially responsible for all charges for services and agree to make payments promptly and provide insurance information when appropriate. I assign payment of my accepted insurance benefits for this care to Dr. Jane Torrie, DC and Oasis Chiropractic and Wellness Center.

Signature_____ _____

Patient or Guardian Date