Skinner Chiropractic/Southside Chiropractic/Skinner Wellness

3198 Custer Dr. Ste 100
Lexington, KY 40517

Patient Name: _____ Date: _____ Email: _____

SS #/SIN: _____ DOB: _____ □ Male □Female Home Phone: _____ Cell Phone: _____

Check appropriate box**:** □Minor □Single □Married □Divorced □Widowed □Separated

Patient's Address: _____City: _____ ST: _____ Zip: _____

Employer Name: _____

Spouse/Patient's Guardian Name: _____ Spouse's Employer: _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency:_____ Phone: _____

Responsible Party

Name of person responsible for this account: _____ Relationship to patient: _____

Address: _____ Home phone: _____

Email: _____ Cell phone: _____

Driver's License #: _____ Date of Birth: _____

Is this person currently a patient at our office? □ Yes □ No

Do you have any medical insurance? □ Yes □ No If yes, complete the following:

Name of the Insured: _____ Relationship to patient: _____

DOB: _____ SS#/SIN: _____ Employer Name: _____ Work Phone: _____

Employer Address: _____ City: _____ ST: ____ Zip: _____

Insurance Company: _____ Group #: _____ Union or local #: _____

Insurance Company Address:_____ City: _____ ST: ____ Zip: _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS,
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I certify that all information is true and correct. I hereby authorize the release of any information required by this office. I also authorize my benefit payments to be made directly to this clinic. If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct my insurance company to make out the check to me and mail it to this office. I understand that I am financially responsible for all the services rendered. I agree that if my treatment here is suspended or terminated, bills become immediately due and payable. All x-rays are property of Skinner Chiropractic/Southside Chiropractic/Skinner Wellness. I authorize Skinner Chiropractic/Southside Chiropractic/Skinner Wellness to file a written formal complaint to the insurance commissioner, or Department of Labor, on my behalf. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

X_____
Patient Signature

X_____
Patient Name Printed

Date: _____

X_____
Signature of Guardian, if applicable

Skinner Chiropractic/South Side Chiropractic/Skinner Wellness

Patient Name: _____ DOB: _____ Date: _____

Chief Complaint: _____

History of Present illness:

Location: _____
(Where is the pain/problem?)

Quality: _____
(Example: normal vs abnormal color, activity, etc..)

Severity: _____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: _____
(How long have you had this pain/ problem? When did it start?)

Timing: _____
(Does the pain/problem occur at a specific time?)

Context: _____
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms: _____
(What other associated problems have you been having?)

Aggravating factors: _____
_____
(What makes the pain/problem worse? Have you had previous episodes?)

Relieving factors: _____
_____
(What makes the pain/problem better?)

Complete this section if due to an accident

Type of accident:
- Auto
- Workers Comp
- Fall
- Other: _____

Date of accident: _____

Brief description of accident:
_____
_____
_____
_____
_____

Past Medical History

Please check the box if you have had any of the following:

- ☐ Measles/Mumps
- ☐ Chicken Pox
- ☐ Whooping Cough
- ☐ Scarlet Fever
- ☐ Rheumatic Fever
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ If yes, last x-ray? _____
- ☐ Asthma
- ☐ Bronchitis
- ☐ Anemia
- ☐ Blood/Plasma Transfusion
- ☐ Bleeding Tendency
- ☐ Ulcer
- ☐ Hepatitis
- ☐ Recurrent Bladder Infection
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Back Trouble
- ☐ Migraine Headaches
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Peripheral Vascular Disease
- ☐ Stroke
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Glaucoma
- ☐ Cancer

Other:
_____
_____
_____
_____

Previous Hospitalizations/Surgeries/Serious Illnesses

Please include location and date

_____
_____
_____

_____
_____
_____

Health Screenings:

Last pap:	Last colonoscopy:	Last pneumonia shot:
Last mammogram:	Last PSA/DRE:	Last tetanus shot:
Last bone density:	Last flu shot:	

_____ _____
Signature of Provider Date

Skinner Chiropractic/South Side Chiropractic/Skinner Wellness

Patient Name: _____ DOB: _____ Date: _____

Allergies:

_____

_____

Medications: (include nonprescription)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Social History:

Occupation: _____

Marital Status: M S W D

Alcohol Use: Never: ___ Rarely: ___ Moderate: ___ Daily: ___

Type: _____

Tobacco Use: Never: ___ Current: _____ packs per day x ____ yrs

Former: ____ packs per day x ___ yrs

Use of Drugs Never: ___

Type/Frequency: _____

Excessive Exposure at home or at work to: Fumes: _____

Dust: _____ Solvents: _____ Airborne Particles: _____

Noise: _____

Family Medical History:

	Age	Disease	If deceased, cause of death
Mother			
Father			
Brother			
Sister			
Children			
Other			

Review of Systems (Check here ☐ if no symptoms to report)

Please check the box if you have had any of the following in the past 1-2 months

- ☐ Asthma
- ☐ Stuffy nose
- ☐ Hay fever
- ☐ Sore throat
- ☐ Chronic cough
- ☐ Chest congestion
- ☐ Frequent sneezing
- ☐ Itchy/watery eyes
- ☐ Sinus drainage
- ☐ Earache/ear infection
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Chest pain
- ☐ Fatigue
- ☐ Malaise
- ☐ Weakness/tiredness
- ☐ Lightheadedness
- ☐ Irritability
- ☐ Constipation
- ☐ Diarrhea
- ☐ Burning with urination
- ☐ Blood in urine
- ☐ Blood in stool
- ☐ Feeling foggy
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Numbness
- ☐ Tinging
- ☐ Pins/needles in hands/feet
- ☐ Muscle aches
- ☐ Joint pain
- ☐ Low back pain
- ☐ Neck pain
- ☐ Wrist/hand pain
- ☐ Elbow pain
- ☐ Shoulder pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle/foot pain
- ☐ Pain between shoulder blades

_____ _____

Signature of Provider Date