CONFIDENTIAL PATIENT INFORMATION

Dr. John Amy * **Edinboro Family Chiropractic** * Dr. Matthew Joyce
12650 Edinboro Road * Edinboro, PA 16412 * P: (814) 734-4541 * F: (814) 734-5562

Name____ D.O.B.______________

Address____ Home Phone_______________

City______________________State_______ Zip Code________ Cell Phone__________________

Do you have an Advanced Health Care Directive? Y / N

*****If yes – you will need to immediately provide us with a copy to keep in your permanent record as per Pennsylvania ACT 169*****

S.S.N.: _____-_____-________ (Why do we need it? Needed for Imaging/Specialist referrals and/or Insurance Authorization)

Student: Y / N **Sex:** M / F **Marital Status:** Single – Married – Widowed –Divorced – Partnered – Separated

Do you have Health Insurance? Y / N If so, name of insurance: ______________________________

Who is financially responsible for this bill? ____

Employer____________________________ Occupation_______________________

Employer address______________________________ Work Phone: ______________________

Emergency Contact________________________________Relationship:_________________

Home Phone: ________________________ Cell phone:_______________________

Address____

Where have you seen or heard about our office (circle all that apply)?

Phone book Internet Friend/Family Health Fair Billboard Poster Lecture

If Friend/Family, please give name____

May we have your permission to send a thank you letter? Y / N

HISTORY OF INJURY

Describe your major complaint____

Is it Work or Auto Related? Y / N Work / Auto Date of Injury: ____/____/________

Date when this current episode began ____/____/________

Have you lost work due to the injury? **YES / NO** If so, dates_________________________

Have you seen a Physician for the present complaint? **YES / NO** Who & When_______________

Did the Physician have any X-rays/MRI/CT Scan taken? **YES / NO** Where__________________

Please Rate the Severity of your problem – **Occasional – Mild – Moderate – Severe**

PAST MEDICAL HISTORY

Previous Operations:____

Serious Illnesses:____

Hospitalizations: ____

When:__________________________________ Name of Hospital:_________________________

Turn Over→

Family History (Mother, Father, Grandparents) (circle all that apply):

Osteoporosis Diabetes Stroke/Heart attack Heart problems Genetic disorder Cancer(s)
Parkinson's Bleeding disorders High blood pressure Multiple sclerosis Unknown

Other: ________________

Who is your Family Physician ____

Are you under a Doctors Care at this time? __________ For ______________________________

List any medications (with amount), vitamins or supplements you are taking (if you have a list, we can copy it):

____

____

Do you have any Sensitivities or Drug Allergies? ____________________________________

Date of Last Physical Exam ____________________________ Height __________ Weight __________

Review of Systems (Circle any of the symptoms you are currently experiencing):

Dizziness	Lightheaded	Shortness of breath	Asthma	Visual disturbances
Seizures	Fever	Rash	Heart trouble	High blood pressure
Prolonged bleeding	Chest pain	Easy bruising	Excessive fatigue	Nervousness
Sinus trouble	Diabetes	Weakness	Neuritis	Digestive disorders
Tingling	Numbness	Night sweats	Abdominal pain	Painful menstrual cycle
Headaches	Cancer ______________________			

Have you ever had Chiropractic Care? Y / N Who & When ______________________________

Have you ever had Massage Therapy? Y / N Who & When ______________________________

Have you ever had Physical Therapy? Y / N Who & When ______________________________

Social History:

Are you a current smoker? Y / N How long have you smoked? ______ Packs/day ______

Former Smoker? Y / N How long did you smoke? ______ Packs/day ______

How long since you quit? ________

Do you currently drink alcohol? Y / N If yes, how often? _____Drinks/day

Do you use illicit drugs? Y / N

FEMALES ONLY Is there any possibility you are pregnant? _________ If so how many weeks? _______

Date of Last Menstrual Cycle ____

(Please mark none if you have gone through Menopause or due to birth control shots)

I have disclosed all my known health history and information truthfully and to the best of my knowledge.

Patient (or guardian) signature ______________________________________ Date ____________

Patient Name (print)______________________________ Date:______________

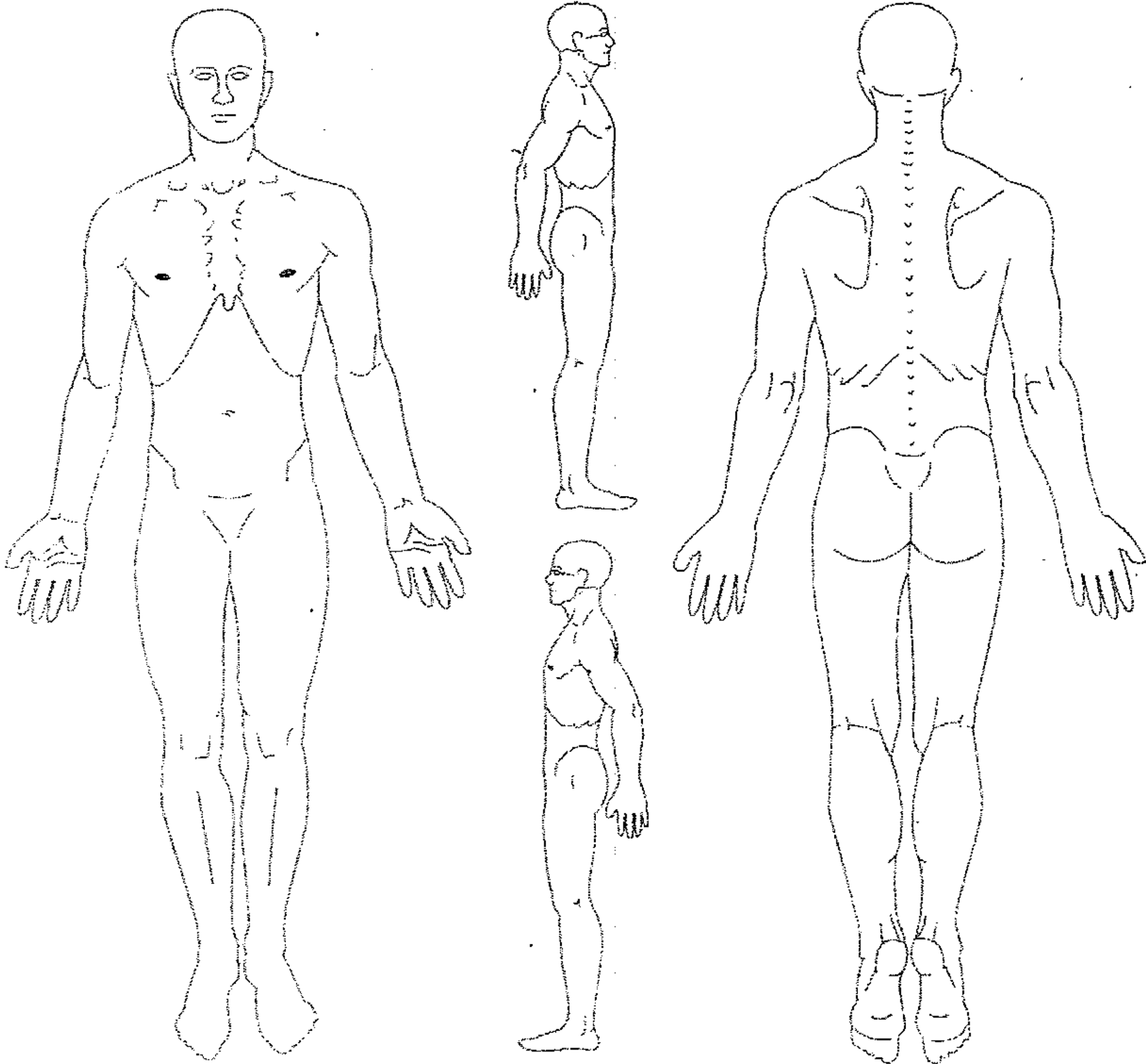
Patient ID #___________

Please draw the location of your pain or discomfort on the images below.
Use the symbols shown to represent the type(s) of pain:

****** = Dull ///////// = Stabbing/Cutting

xxxxxx = Burning OOOO = Tingling (Pins & Needles)

------ = Numb ^^^^^^ = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right now:

No Pain Unbearable Pain

|---|

Rate your pain at its best in the past week:

No Pain Unbearable Pain

|---|

Rate your average pain in the past week:

No Pain Unbearable Pain

|---|

Rate your worst pain in the past week:

No Pain Unbearable Pain

|---|

Patient Signature: ______________________________