ATC
AMBERWOOD TERRACE CHIROPRACTIC

663 CR17, Suite 3
Elkhart, IN 46516
574-522-2255

PATIENT INFORMATION FORM

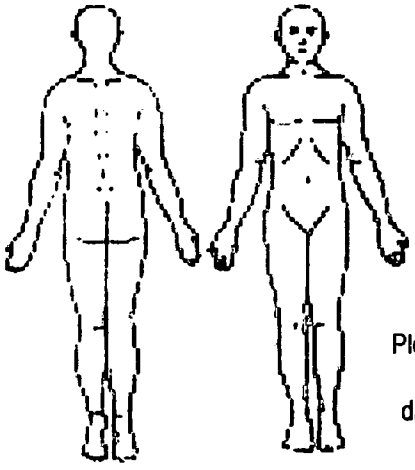
NAME:	☐ MALE ☐ FEMALE	AGE:	☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED ☐ _____
TODAYS DATE:		DATE OF BIRTH:	
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE:	CELL:	FAX:	
SOCIAL SECURITY #:	DRIVER'S LICENSE #:	STATE:	E-MAIL ADDRESS:
SPOUSES NAME:	AGES OF CHILDREN:		OCCUPATION/JOB TITLE:
EMPLOYER/BUSINESS NAME:	BUSINESS ADDRESS:		
BUSINESS PHONE:	TYPE OF WORK:		
HOW DID YOU HEAR ABOUT US?			
EMERGENCY CONTACT:		PHONE #:	
ADDRESS:		RELATIONSHIP:	

INSURANCE

WHO IS RESPONSIBLE FOR YOUR BILL? ☐ SELF ☐ AUTO INSURANCE ☐ MEDICAID ☐ WORKER'S COMP ☐ MEDICARE ☐ OTHER (BE SPECIFIC).

PERSONAL HEALTH INSURANCE CARRIER:	HEALTH ID CARD #:
INSURED PERSON'S NAME:	GROUP #:
INSURED PERSON'S DATE OF BIRTH:	PRIMARY CARE PHYSICIAN:
INSURED PERSON'S SOCIAL SECURITY #:	PHARMACY:

CURRENT HEALTH CONDITION



Please circle areas of discomfort.

CHIEF COMPLAINT: (WHY ARE YOU HERE TODAY?)

BODY AREA INVOLVED: ☐ CERVICAL (NECK) ☐ SPINE (MID-BACK), RIBS, PELVIS (LOW BACK) ☐ UPPER EXTREMITY (ARMS, WRIST, HANDS) ☐ LOWER EXTREMITY (LEGS, FEET, TOES)

CONDITION: ☐ NEW ☐ RECURRING ☐ EXACERBATION ☐ CHRONIC

MECHANISM OF ONSET: ☐ AUTO ☐ WORK ☐ FALL ☐ LIFTING ☐ OVER EXERTION ☐ REPETITIVE MOTION ☐ UNKNOWN ☐ SLEPT WRONG ☐ SLIP OR FALL ☐ NO INJURY ☐ OTHER

SYMPTOMS: ☐ PAIN ☐ NUMBNESS ☐ STIFFNESS ☐ WEAKNESS

LOCATION: ☐ LEFT ☐ RIGHT ☐ BILATERAL

QUALITY SHOOTING: ☐ BURNING ☐ DIFFUSE ☐ DULL/ACHING ☐ LOCALIZED ☐ SHARP ☐ SHOOTING ☐ STABBING ☐ THROBBING ☐ TIGHTNESS ☐ TINGLING ☐ RADIATING ☐ OTHER

CURRENT HEALTH CONDITION (CON'T)

ON A SCALE OF 0-10, (10 BEING THE WORST) WHAT IS THE LEVEL OF IMPAIRMENT DUE TO SYMPTOMS **(RESTING)**:

ON A SCALE OF 0-10, (10 BEING THE WORST) WHAT IS THE LEVEL OF IMPAIRMENT DUE TO SYMPTOMS **(WITH ACTIVITY)**:

DURATION: SYMPTOM(S) STARTED:

SYMPTOM(S) WORSENED:

SYMPTOM(S) LAST OCCURRED:

SYMPTOM(S) LAST EPISODE:

INJURY OCCURRED:

ACCIDENT OCCURRED:

TIMING WORSE IN THE: ☐ MORNING ☐ AFTERNOON ☐ NIGHT ☐ W/ACTIVITY ☐ CONSTANT ☐ INTERMITTENT

ASSOCIATED SIGNS & SYMPTOMS:
☐ BLURRED VISION ☐ HEADACHES ☐ STIFFNESS ☐ IN EARS
☐ DEPRESSION ☐ IRRITABILITY/MOOD SWING ☐ NAUSEA ☐
☐ DIZZINESS ☐ LOCALIZED TINGLING ☐ RINGING

QUALITY OF HEADACHES: ☐ DULL ☐ SHARP ☐ THROBBING ☐ STABBING ☐ AURA ☐ NO AURA

RADIATION: ☐ LEFT ☐ RIGHT ☐ BILATERAL
WEAKNESS: ☐ LEFT ☐ RIGHT ☐ BILATERAL

OTHER ASSOC SIGNS & SYMPTOMS:
☐ ACHES ☐ FEVER ☐ NUMBNESS ☐ RUNNY NOSE ☐ TINGLING
☐ COLD LIMB ☐ HEARTBURN ☐ PALE BLUISH SKIN ☐ STIFFNESS ☐ VOMITING
☐ DIZZINESS ☐ MUSCLE SPASM ☐ PANIC ☐ SWEATING ☐ WEAKNESS
☐ FATIGUE ☐ NAUSEA ☐ PINS & NEEDLES ☐ SWELLING ☐

MODIFYING FACTORS - SYMPTOMS BETTER WITH:
☐ ACTIVITY ☐ COLD ☐ MASSAGE ☐ OTC MEDS ☐ REST ☐ SITTING ☐ TWISTING ☐ NOTHING HELPS
☐ BENDING ☐ HEAT ☐ MOVEMENT ☐ RX MEDS ☐ STRETCHING ☐ STANDING ☐ WALKING

SINCE CONDITION BEGAN, HAS ANYTHING PERMANENTLY HELPED YOU? ☐ YES ☐ NO

HAS ANYTHING THAT YOU HAVE DONE, THUS FAR, FIXED YOUR PROBLEM? ☐ YES ☐ NO

EMPLOYMENT

OCCUPATION:

WORK (HRS/DAY):

JOB CLASSIFICATION: ☐ SITTING ☐ LIGHT ☐ MODERATE ☐ HEAVY LIFTING

LIFTING FREQUENCY: ☐ CONSTANT (66-100% DAY) ☐ FREQUENT (33-65% DAY) ☐ OCCASIONAL (0-32% DAY)

WORK ACTIVITY POSTURES: (HRS/DAY)
☐ SITTING ☐ WALKING ☐ PUSHING ☐ KNEELING ☐ TWISTING
☐ STANDING ☐ CLIMBING ☐ PULLING ☐ REACHING

REPETITIVE ACTIVITIES: (HRS/DAY)
☐ COMPUTER ☐ MACHINERY ☐ ASSEMBLY
☐ PHONE ☐ HAND TOOLS ☐ GRASPING

HOW DOES THIS CONDITION EFFECT JOB PERFORMANCE:
☐ MILD PAINFUL (CAN DO) ☐ SEVERE (UNABLE TO PERFORM)
☐ MODERATE PAINFUL (LIMITED) ☐ OTHER (EXPLAIN):

DAILY ACTIVITIES: EFFECTS OF CURRENT CONDITION ON PERFORMANCE:

ACTIVITY (place a check in column applicable)	NO EFFECT	MILD PAINFUL (CAN DO)	MOD. PAINFUL (LIMITED)	SEVERE (UNABLE TO PERFORM)	ACTIVITY (place a check in column applicable)	NO EFFECT	MILD PAINFUL (CAN DO)	MOD. PAINFUL (LIMITED)	SEVERE (UNABLE TO PERFORM)
Bicycling					Running				
Carrying Groceries					Self Care - Dressing				
Change Posn-Sit-Stand					Self Care - Shaving				
Child Care					Sexual Activities				
Climb Stairs					Sleep				
Computer Use					Static Sitting				
Daily Pet Care					Static Standing				
Driving					Swimming				
Exercise					Walking				
Golf					Weight Lifting				
Household Chores					Yard Work				
Lift Children									
Pilates									

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

REVIEW OF SYMPTOMS - Please fill out all of the sections, even if "DENY"

CONSTITUTIONAL: ☐ I DENY ANY CONSTITUTIONAL ISSUE(S)
☐ CHILLS ☐ NIGHT SWEATS ☐ WEIGHT GAIN ☐ DAYTIME SOMNOLENCE (DROWSINESS) ☐ WEIGHT LOSS ☐ FEVER ☐ FATIGUE

EYE/VISION: ☐ I DENY ANY EYES/VISION ISSUE(S)
☐ BLINDNESS ☐ DOUBLE VISION ☐ EYE PAIN ☐ PHOTOPHOBIA ☐ TEARING ☐ BLURRED VISION ☐ FIELD CUTS (VISUAL FIELD DEFECT) ☐ CATARACTS ☐ GLAUCOMA ☐ CHANGE IN VISION ☐ ITCHING (AROUND EYES) ☐ WEAR GLASSES AND/OR ☐ CONTACT LENSES

EARS, NOSE AND THROAT: ☐ I DENY ANY E/N/T ISSUE(S)
☐ BLEEDING ☐ DISCHARGE ☐ DIZZINESS ☐ SNORING ☐ FAINTING ☐ HEADACHES ☐ LOSS OF SMELL ☐ SORE THROATS (FREQUENT) ☐ NASAL CONGESTION ☐ SINUS INFECTIONS ☐ DENTAL IMPLANTS ☐ EAR DRAINAGE ☐ EAR INFECTION(S) ☐ HEARING LOSS ☐ TINNITUS (RINGING IN EARS) ☐ POST NASAL DRIP ☐ DIFFICULTY SWALLOWING ☐ EAR PAIN ☐ HOARSENESS ☐ RHINORRHEA (RUNNY NOSE) ☐ SINUS INFECTIONS ☐ TMJ PROBLEMS

RESPIRATION: ☐ I DENY ANY RESPIRATORY ISSUE(S)
☐ ASTHMA ☐ COUGHING UP BLOOD ☐ SPUTUM PRODUCTION ☐ COUGH ☐ SHORTNESS OF BREATH ☐ WHEEZING

CARDIOVASCULAR: ☐ I DENY ANY CARDIOVASCULAR ISSUE(S)
☐ ANGINA (CHEST PAIN OR DISCOMFORT) ☐ CHEST PAIN ☐ CLAUDICATION (LEG PAIN OR ACHINESS) ☐ HEART MURMUR ☐ HEART PROBLEMS ☐ ORTHOPNEA (DIFFICULTY BREATHING WHILE LYING DOWN ☐ PALPITATIONS (IRREGULAR OR FORCEFUL BEATING OF THE HEART) ☐ PAROXYSMAL NOCTURNAL DYSPNEA (WAKING AT NIGHT WITH SHORTNESS OF BREATH) ☐ SWELLING OF LEGS ☐ ULCERS ☐ VARICOSE VEINS

GASTROINTESTINAL ☐ I DENY ANY GASTROINTESTINAL ISSUE(S)
☐ ABDOMINAL PAIN ☐ BELCHING ☐ BLACK, TARRY STOOLS ☐ CONSTIPATION ☐ DIARRHEA ☐ DIFFICULTY SWALLOWING ☐ HEARTBURN ☐ HEMORRHOIDS ☐ INDIGESTION ☐ JAUNDICE (YELLOWING OF SKIN) ☐ NAUSEA ☐ RECTAL BLEEDING ☐ ABNORMAL STOOL CALIBER (QUALITY) ☐ ABNORMAL STOOL COLOR ☐ ABNORMAL STOOL CONSISTENCY ☐ VOMITING ☐ VOMITING BLOOD

FEMALE ☐ I DENY ANY FEMALE ISSUE(S)
☐ BIRTH CONTROL THERAPY ☐ BREAST LUMP/PAIN ☐ BURNING URINATION ☐ CRAMPS ☐ FREQUENT URINATION ☐ HORMONE THERAPY ☐ IRREGULAR MENSTRUATION ☐ URINE RETENTION ☐ VAGINAL BLEEDING ☐ VAGINAL DISCHARGE

MALE ☐ I DENY ANY MALE ISSUE(S)
☐ BURNING URINATION ☐ PROSTATE PROBLEMS ☐ ERECTILE DYSFUNCTION ☐ FREQUENT URINATION ☐ URINATION RETENTION ☐ HESITANCY/DRIBBLING

ENDOCRINE: ☐ I DENY ANY ENDOCRINE ISSUE(S)
☐ COLD INTOLERANCE ☐ DIABETES ☐ EXCESSIVE APPETITE ☐ EXCESSIVE HUNGER ☐ EXCESSIVE THIRST ☐ FREQUENT URINATION ☐ GOITER ☐ HAIR LOSS ☐ HEAT INTOLERANCE ☐ UNUSUAL HAIR GROWTH ☐ VOICE CHANGES

SKIN: ☐ I DENY ANY SKIN ISSUE(S)
☐ CHANGES IN NAIL TEXTURE ☐ CHANGES IN SKIN COLOR ☐ HAIR GROWTH ☐ HAIR LOSS ☐ HIVES ☐ ITCHING ☐ PARESTHESIA (NUMBNESS, PRICKLING, OR TINGLING) ☐ RASH ☐ HISTORY OF SKIN DISORDERS ☐ SKIN LESIONS/ULCERS ☐ VARICOSITIES

NERVOUS SYSTEM: ☐ I DENY ANY NERVOUS SYSTEM ISSUE(S)
☐ DIZZINESS ☐ FACIAL WEAKNESS ☐ HEADACHES ☐ LIMB WEAKNESS ☐ LOSS OF CONSCIOUSNESS ☐ LOSS OF MEMORY ☐ NUMBNESS ☐ SEIZURES ☐ SLEEP DISTURBANCE ☐ STRESS ☐ STROKES ☐ TREMORS ☐ UNSTEADINESS OF GAIT

PSYCHOLOGIC: ☐ I DENY ANY PSYCHOLOGIC SYSTEM ISSUE(S)
☐ ANHEDONIA (INABILITY TO EXPERIENCE JOY OR ENJOY LIFE) ☐ ANXIETY ☐ APPETITE CHANGES ☐ BEHAVIORAL CHANGE(S) ☐ BIPOLAR DISORDER ☐ CONFUSION ☐ CONVULSIONS ☐ DEPRESSION ☐ INSOMNIA ☐ MEMORY LOSS ☐ MOOD CHANGE(S)

ALLERGY: ☐ I DENY ANY ALLERGY ISSUE(S)
☐ ANAPHYLAXIS (HISTORY OF SNEEZING) ☐ FOOD INTOLERANCE ☐ ITCHING ☐ NASAL CONGESTION ☐ SNEEZING

HEMATOLOGY: ☐ I DENY ANY HEMATOLOGIC ISSUE(S)
☐ ANEMIA ☐ BLEEDING ☐ BLOOD CLOTTING ☐ BLOOD TRANSFUSION(S) ☐ BRUISES EASILY ☐ FATIGUE ☐ LYMPH NODE SWELLING

PAST HEALTH HISTORY - Please fill out carefully as these problems can affect your overall course of care.

CHILDHOOD ILLNESS: ☐ I DENY ANY CHILDHOOD ILLNESS(ES)
☐ ADD ☐ ALLERGIES/HAYFEVER ☐ ASTHMA ☐ ATOPIC DERMATITIS (ECZEMA) ☐ BED WETTING ☐ CEREBRAL PALSY ☐ CHICKEN POX ☐ DEPRESSION ☐ DIABETES ☐ EAR INFECTIONS ☐ FETAL DRUG ☐ EXPOSURE ☐ FOOD ALLERGIES ☐ HEADACHES ☐ HEPATITIS ☐ HIV ☐ MEASLES ☐ MUMPS ☐ RASH ☐ SCOLIOSIS ☐ SEIZURE DISORDER ☐ SICKLE CELL ANEMIA ☐ SPINA BIFIDA ☐ OTHER (PLEASE DESCRIBE)

ADULT ILLNESS: ☐ I DENY ANY ADULT ILLNESS(ES)
☐ ALZHEIMERS ☐ ANEMIA ☐ ARTHRITIS ☐ ASTHMA ☐ CANCER ☐ CHICKEN POX ☐ CROHN'S/COLITIS ☐ CRPS (RSD) ☐ CVA (STROKE) ☐ CYSTIC KIDNEY DISEASE ☐ DEPRESSION ☐ DIABETES (INSULIN) ☐ DIABETES (NON INSULIN) ☐ EAR INFECTIONS (FREQUENT) ☐ EMPHYSEMA ☐ EYE PROBLEMS ☐ FIBROMYALGIA ☐ HEART DISEASE ☐ HEPATITIS ☐ HIV ☐ HYPERTENSION ☐ INFLUENZAL PNEUMONIA ☐ LIVER DISEASE ☐ LUNG DISEASE ☐ LUPUS ERYTHEMA (DISCOID) ☐ LUPUS ERYTHEMA (SYSTEMIC) ☐ MULTIPLE SCLEROSIS ☐ PARKINSON'S DISEASE ☐ PLEURISY ☐ PNEUMONIA ☐ PSYCHIATRIC PROBLEMS ☐ SCOLIOSIS ☐ SEIZURE DISORDER ☐ SHINGLES ☐ STD'S (UNSPECIFIED) ☐ SUICIDE ATTEMPT(S) ☐ THYROID PROBLEMS ☐ VERTIGO ☐ PAST HISTORY OF SIMILAR SYMPTOMS TO YOUR CURRENT CONDITION
☐ OTHER _____

PAST HEALTH HISTORY (CON'T)

SURGERIES: I ☐ DENY ANY SURGERY (IES)

☐ ANGIOPLASTY ☐ APPENDECTOMY ☐ CAESAREAN SECTION ☐ CARDIAC CATHETERIZATION ☐ CARPAL TUNNEL REPAIR
☐ CORONARY ARTERY BYPASS ☐ COSMETIC ☐ D & C ☐ DENTAL SURGERY ☐ GALL BLADDER
☐ HEMORRHOIDECTOMY ☐ HERNIA REPAIR ☐ HYSTERECTOMY ☐ JOINT RECONSTRUCTION ☐ JOINT REPLACEMENT
☐ LAMINECTOMY ☐ MASTECTOMY ☐ PACEMAKER INSERTION ☐ ROTATOR CUFF ☐ SPINAL FUSION
☐ TONSILLECTOMY ☐ OTHER (PLEASE BE SPECIFIC): _____ _____

OB/GYN: I ☐ DENY ANY OB/GYN ISSUE(S)

☐ I HAVE NEVER BEEN PREGNANT ☐ I HAVE BEEN PREGNANT IN THE PAST ☐ I AM CURRENTLY PREGNANT

MENSTRUAL HISTORY: AGE OF ONSET _____

☐ MY MENSES IS REGULAR ☐ MY MENSES IS IRREGULAR ☐ I AM CURRENTLY IN MENOPAUSE DATE OF LAST MENSES ____/____/____

INJURIES: I ☐ DENY ANY INJURY (IES)

☐ BACK INJURY ☐ BROKEN BONES ☐ SEVERE FALL ☐ FRACTURE ☐ DISABILITY ☐ HEAD INJURY ☐ INDUSTRIAL ACCIDENT ☐ JOINT INJURY ☐ SEVERE LACERATION ☐ MOTOR VEHICLE ACCIDENT ☐ MILD/MODERATE SOFT TISSUE INJURY ☐ SEVERE SOFT TISSUE INJURY

IMMUNIZATIONS: I ☐ DENY ANY IMMUNIZATION(S)

☐ DTaP (DIPTHERIA, TETANUS & PERTUSSIS) ☐ FLU ☐ HEPATITIS A ☐ HEPATITIS B ☐ HEPATITIS C ☐ INFLUENZA ☐ IPV (POLIO) ☐ MMR (MEASLES, MUMPS & RUBELLA) ☐ PNEUMOCOCCAL ☐ PPD (MANTOUX TEST-TB) ☐ SMALL POX ☐ TB ☐ VARIVAX (CHICKEN POX) ☐ WHUPPING COUGH (PERTUSSIS)

NON-DRUG ALLERGIES: I ☐ DENY ANY NON-DRUG ALLERGIES

☐ ANIMALS ☐ DAIRY ☐ EGGS ☐ FOOD COLORING ☐ MOLD ☐ POLLEN

PREVIOUS TREATMENT

PREVIOUS CHIROPRACTIC CARE? ☐ YES ☐ NO IF YES, WHO? (NAME)

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? ☐ YES ☐ NO IF YES, WHO? (NAME) | LOCATION OF OFFICE | TYPE OF TREATMENT:

WERE YOU SATISFIED WITH THE RESULTS OF YOUR TREATMENT? ☐ YES ☐ NO EXPLAIN:

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATIONS? ☐ YES ☐ NO IF YES, PLEASE MARK OR LIST (BE SPECIFIC). ☐ ALLERGY MEDICATION ☐ ANTI-DEPRESSANTS ☐ BLOOD PRESSURE MEDS ☐ INSULIN ☐ MUSCLE RELAXERS ☐ NERVE PILLS ☐ PAIN KILLERS ☐ OTHER (PLEASE SPECIFY)

DO YOU WEAR ANY OF THE FOLLOWING? ☐ HEAL LIFTS ☐ INNER SOLES ☐ ARCH SUPPORTS ☐ ORTHOTICS

PLEASE LIST ANY OTHER CONDITIONS YOU FEEL WE SHOULD KNOW ABOUT - EVEN IF UNRELATED:

FAMILY HISTORY - ENTER INITIALS BELOW: A = ALIVE D = DECEASED

_____ GENERAL FAMILY _____ MOTHER _____ PATERNAL GRANDMOTHER _____ MATERNAL GRANDMOTHER _____ DAUGHTER(S) _____ SISTER(S)

_____ FATHER _____ PATERNAL GRANDFATHER _____ MATERNAL GRANDFATHER _____ SON(S) _____ BROTHER(S)

NAME	RELATION	PAST & PRESENT HEALTH PROBLEMS

SOCIAL HISTORY

ALCOHOL: ☐ NEVER ☐ WEEKLY ☐ SOCIAL ☐ DAILY ☐ MONTHLY ☐ CONSUMPTION ONLY ☐ BEER ☐ WINE OZ.'S # GLASSES ☐ LIQUOR

DIET: Mark all that apply ☐ HIGH FAT ☐ HIGH PROTEIN ☐ LOW CALORIE ☐ LOW FIBER ☐ LOW ☐ HIGH FIBER ☐ HIGH SALT ☐ LOW CARB ☐ LOW SALT SUGAR

DRUGS: ☐ DENY ANY ILLEGAL DRUG USE ☐ DENY USE OF IV DRUGS ☐ HAVE NOT USED DRUGS SINCE_____ ☐ HAVE USED DRUGS FOR _____

TOBACCO: ☐ DENY TOBACCO USE ☐ QUIT ☐ LIVE W/A SMOKER # PER: SMOKING ____ ☐ DAY ☐ WEEK ☐ MONTH ☐ # CHEW _____

PLEASE READ CAREFULLY AND SIGN BELOW:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the x-rays are for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. I also agree that I am responsible for all bills incurred at this office. I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

GUARDIAN OR SPOUSE'S SIGNATURE OF AUTHORIZING CARE: (SIGNATURE INDICATES CONSENT TO TREAT)		**DATE:**
PATIENT (PRINT NAME):	**PATIENT'S SIGNATURE:** X	**DATE:**