ABOUT THE PATIENT

Ryan Scotting DC

Name ______________________________ Today's Date__________ Birthdate __________ Age_________

Address ______________________________ City ____________________ State _____ Zip __________

Home Phone ________________ Cell Phone ________________ Work Phone ________________Gender ❑ M ❑ F

Height ________ Weight _________ Blood Pressure _____/_____ Soc Sec# ___________ How Did You Hear of Dr.Scotting?__________

Significant Other's Name ______________________ Kid's Names and Ages ______________________________

Your Employer ______________________________ Type of Work ______________________________

E-Mail Address ______________________________ Have you been to a chiropractor before? ☐ No ☐ Yes

Emergency Contact ____________________ Ph # ______________ Insurance Co ________________

Insurance ID # ____________________ Name of Medical Doctor(s)______________________________

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Dr. Scotting to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?________________________
- I understand that all or some services may or may not be covered by Medicare.
- I understand I am responsible for services not covered by Medicare.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

____ ____________________

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. ______________________________________ How long has this been an issue? ________________

   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to__________________

2. ______________________________________ How long has this been an issue? ________________

   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to__________________

3. ______________________________________ How long has this been an issue? ________________

   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to__________________

4. ______________________________________ How long has this been an issue? ________________

   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to__________________

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

____

6. What makes it better?______________________________________

7. What makes it worse? ______________________________________

8. What Doctor's have you seen for this?__________________________

____

9. Type of treatment:____

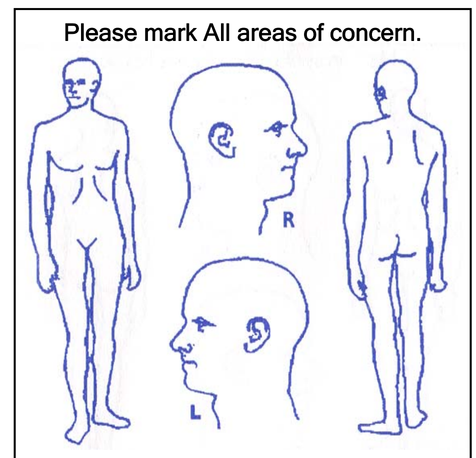
10. Results: ____

NOTES: ____

____

____

Please mark All areas of concern.



GENERAL HEALTH HISTORY

Ryan Scotting DC

Patient Name____ *Mark the conditions that apply to you.*

Past	Present	Condition
❑	❑	Headaches
❑	❑	Migraines
❑	❑	Shortness of Breath
❑	❑	Allergies/Asthma
❑	❑	Diabetes
❑	❑	Cold Hands or Feet
❑	❑	Muscle Aches
❑	❑	Trouble Walking
❑	❑	Leg/ Foot Numbness
❑	❑	Fainting
❑	❑	Gall Bladder Trouble
❑	❑	Ringing in Ears
❑	❑	Ear Problems
❑	❑	Sleeping Problems
❑	❑	Vision Problems
❑	❑	Thyroid Problems
❑	❑	Liver Disease
❑	❑	Kidney Problems

Past	Present	Condition
❑	❑	Urinary Problems
❑	❑	Easy Bruising
❑	❑	Dental Problems
❑	❑	Fibromyalgia
❑	❑	Blood Thinner Use
❑	❑	HIV Positive
❑	❑	Cancer
❑	❑	Depression
❑	❑	__High or __ Low Blood Pressure
❑	❑	Stroke History
❑	❑	High Cholesterol
❑	❑	TMJ
❑	❑	Digestive Problems
❑	❑	Pain All Over
❑	❑	Tension/ Irritability
❑	❑	Chest Pains
❑	❑	Heart Pacemaker
❑	❑	Heart Problems

❑ ❑ Other ____

Smoking Status: Current/ Everyday Current/ some days Former Never

1. Please list all doctors you are currently seeing :____
____
2. List any medications you are taking:____
____
3. List any known allergies: ____
____
____

PAST HISTORY

4. List any past auto collisions:_________________________________ Was any care received?______________
5. List any past work injuries: _________________________________ Was any care received?______________
6. List any past sport, recreational, or home injuries____
7. Please describe any past conditions and treatment received: ______________________________________
____
8. Please list any past hospitalizations and surgeries: ____
____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other__________________

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other__________________

Is there any other family history you want us to know?____