CONFIDENTIAL
HEALTH INFORMIATION

Please allow our staff to photocopy your driver's license and Insurance details. All information you supply is confidential.
We comply with all federal privacy standards.
Please print clearly.

Elevate Sport and Spine Center
2878 Freeport Road
Natrona Heights, PA 15065
(724)226-0100 (p)
(724) 226-0400 (f)
elevatesportandspine@gmail.com
www.elevatesportandspinecenter.com

_____ _____
Today's Date (MM/DD/YYYY) Patient Number (office use only)

Have you consulted a chiropractor before?

_____
How did you hear about us? O No O Yes When? _____ If so, whom? _____

_____ _____ _____ _____
Your Last Name Your Social Security Number Birth Date (MM/DD/YYYY) Age

_____ _____ Gender
Your First Name Your Middle Name (or initial) O Male O Female

_____ Marital Status O Married
Address O Single O Divorced

_____ _____ _____ O Widowed O Separated
City State/Province Zip/Postal Code

_____ _____ _____
Home Phone Cell Phone Spouse's Name

_____ _____
Email Address Child's Name and Age

_____ _____
Emergency Contact Emergency Contact's Phone Child's Name and Age

_____ _____
Your Occupation Child's Name and Age

_____ _____
Your Employer Work Phone

_____ May we contact you at work?
Address O Yes O No

_____ _____ _____ Preferred method of contact?
City State/Province Zip/Postal Code O Home Phone O Cell Phone
O Work Phone O Email

_____
Primary Care Provider's Name

_____ _____
Insurance Carrier Policy Number

_____ _____ Who carries this policy?
Insured's Last Name Birth Date (MM/DD/YYY) O Self O Spouse O Parent

_____ _____
Insured's First Name Insured's Middle Name (or initial)

_____
Insured's Employer

_____
Address

_____ _____ _____ _____
City State/Province Zip/Postal Code Employer's Phone

1. The symptom(s) that have prompted me to seek care today include:_____

_____

2. And are the result of (darken circle): O An accident or injury

O Work O Auto O Other _____

O A worsening long-term problem

O An interest in: O Wellness O Other_____

3. Onset (When did you first notice Your current symptoms?)

_____

4. Intensity (How extreme are your current systems?)

0- O-O-O-O-O-O-O-O-O-O-10

Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)

O Constant O Comes and goes. How Often?_____

_____

6. Quality of symptoms (What does it feel like?)

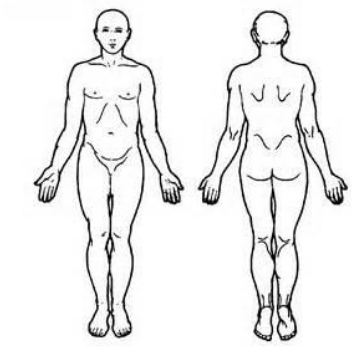
- O Numbness
- O Tingling
- O Stiffness
- O Dull
- O Aching
- O Cramps
- O Nagging
- O Sharp
- O Burning
- O Shooting
- O Throbbing
- O Stabbing
- O Other _____

7. Location(Where does it hurt?)

Circle the area(s) on the illustration.

"O" for current condition

"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of the day, movements, certain activities, etc.)

What tends to worsen the problem?_____

What tends to lessen the problem?_____

10. Prior Interventions (What have you done to relieve the symptoms?)

O Prescription medication	O Surgery	O Ice
O Over-the-counter drugs	O Acupuncture	O Heat
O Homeopathic Remedies	O Chiropractic	O Other_____
O Physical Therapy	O Massage	_____

11. What else should Elevate Sport & Spine know about your current condition?

_____

_____

12. How does your current condition interfere with your:

Work or career:_____

Recreational activities:_____

Household responsibilities:_____

Personal relationships:_____

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle besides any condition that you've **Had** or currently **Have**.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE O
O	O	Osteoporosis	O	O	Arthritis	O	O	Scollosis	O	O	Neck pain	O	O	Back problems	O	O	Hip disorder	
O	O	Knee Injuries	O	O	Foot/Ankle pain	O	O	Shoulder problems	O	O	Elbow/wrist pain	O	O	TMJ Issues	O	O	Poor posture	

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE O
O	O	Anxiety	O	O	Depression	O	O	Headache	O	O	Dizziness	O	O	Pins & Needles	O	O	Numbness	

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE O
O	O	High Blood pressure	O	O	Low Blood pressure	O	O	High cholesterol	O	O	Poor Circulation	O	O	Angina	O	O	Excessive bruising	

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE O
O	O	Asthma	O	O	Apnea	O	O	Emphysema	O	O	Hay fever	O	O	Shortness of breath	O	O	Pneumonia	

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE O
O	O	Anorexia/ bulimia	O	O	Ulcer	O	O	Food sensitivities	O	O	Heartburn	O	O	Constipation	O	O	Diarrhea	

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE O
O	O	Blurred vision	O	O	Ringing in ears	O	O	Hearing loss	O	O	Chronic ear infection	O	O	Loss of smell	O	O	Loss of taste	

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE O
O	O	Skin cancer	O	O	Psoriasis	O	O	Eczema	O	O	Acne	O	O	Hair Loss	O	O	Rash	

_____

Patient Name

_____

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_____

Doctor's Initials

(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE O
O	O	Thyroid issues	O	O	Immune disorders	O	O	Hypoglycemia	O	O	Frequent infection	O	O	Swollen glands	O	O	Low energy	initials____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE O
O	O	Kidney stones	O	O	Infertility	O	O	Bedwetting	O	O	Prostate issues	O	O	Erectile dysfunction	O	O	PMS symptoms	initials_____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE O
O	O	Fainting	O	O	Low libido	O	O	Poor appetite	O	O	Fatigue	O	O	Sudden weight Gain/loss (circle one)	O	O	Weakness	initials_____

Past Personal, Family and Social History

Please Identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section completely.

PERSONAL

14. Illnesses

Check the Illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
O	O	AIDS	O	O	Tuberculosis
O	O	Alcoholism	O	O	Typhoid fever
O	O	Allergies	O	O	Ulcer
O	O	Arteriosclerosis	O	O	Other:_____
O	O	Cancer			_____
O	O	Chicken pox			_____
O	O	Diabetes			_____
O	O	Epilepsy			_____
O	O	Glaucoma			_____
O	O	Goiter			_____
O	O	Gout			_____
O	O	Heart disease			_____
O	O	Hepatitis			
O	O	HIV positive			
O	O	Malaria			
O	O	Measles			
O	O	Multiple Sclerosis			
O	O	Mumps			
O	O	Polio			
O	O	Rheumatic fever			
O	O	Scarlet fever			
O	O	Sexually transmitted Disease			
O	O	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- **O** Appendix removal
- **O** Bypass surgery
- **O** Cancer
- **O** Cosmetic surgery
- **O** Elective surgery:_____ _____
- **O** Eye surgery
- **O** Hysterectomy
- **O** Pacemaker
- **O** Spine _____ _____:_____ _____
- **O** Tonsillectomy
- **O** Vasectomy
- **O** Other:_____ _____ _____ _____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
O	O	Acupuncture
O	O	Antibiotics
O	O	Birth control pills
O	O	Blood transfusions
O	O	Chemotherapy
O	O	Chiropractic care
O	O	Dialysis
O	O	Herbs
O	O	Homeopathy
O	O	Hormone Replacement
O	O	Inhaler
O	O	Massage therapy
O	O	Nutritional supplements

List:_____ _____ _____ _____

O O Medications (prescriptions and over-the-counter):
_____ _____ _____

17. Injuries

Have you ever…

- **O** Had a fractured or broken bone
- **O** Had a spine or nerve disorder
- **O** Had been knocked unconscious
- **O** Been injured in an accident
- **O** Used a crutch or other support
- **O** Used neck or back bracing
- **O** Received a tattoo
- **O** Had a body piercing

FAMILY

18. Family History

Some health issues are hereditary. Tell Elevate Sport & Spine about the health of your immediate family members

Relative	Age (If living)	State of health Good	Poor	Illnesses.	Age at death	Cause of death Natural	Illness
Mother	_____	O	O	_____	_____	O	O
Father	_____	O	O	_____	_____	O	O
Sister 1	_____	O	O	_____	_____	O	O
Sister 2	_____	O	O	_____	_____	O	O
Brother 1	_____	O	O	_____	_____	O	O
Brother 2	_____	O	O	_____	_____	O	O

19. Are there any other hereditary health issues that you know about?_____ _____

SOCIAL

20. Social History

Tell Elevate Sport & Spine about your health habits and stress levels.

Alcohol use	**O Daily**	**O Weekly**	**How Much?** _____	**Prayer or meditation?**	**O Yes**	**O No**
Coffee use	**O Daily**	**O Weekly**	**How Much?** _____	**Job pressure/stress?**	**O Yes**	**O No**
Tobacco use	**O Daily**	**O Weekly**	**How Much?** _____	**Financial peace?**	**O Yes**	**O No**
Exercising	**O Daily**	**O Weekly**	**How Much?** _____	**Vaccinated?**	**O Yes**	**O No**
Pain Relievers	**O Daily**	**O Weekly**	**How Much?** _____	**Mercury fillings?**	**O Yes**	**O No**
Soft Drinks	**O Daily**	**O Weekly**	**How Much?** _____	**Recreational drugs?**	**O Yes**	**O No**
Water Intake	**O Daily**	**O Weekly**	**How Much?** _____			

Hobbies _____

_____
Patient Name

_____
Patient Number
(office use only)

_____
Doctor's Initials

21. Activities of Daily Living

How does this condition currently interfere with your life and abilities to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	O	O	O	O	Grocery Shopping	O	O	O	O
Rising out of chair	O	O	O	O	Household chores	O	O	O	O
Standing	O	O	O	O	Lifting objects	O	O	O	O
Walking	O	O	O	O	Reaching Overhead	O	O	O	O
Laying down	O	O	O	O	Showering or bathing	O	O	O	O
Bending over	O	O	O	O	Dressing myself	O	O	O	O
Climbing stairs	O	O	O	O	Love Life	O	O	O	O
Using a computer	O	O	O	O	Getting to sleep	O	O	O	O
Getting in/out of car	O	O	O	O	Staying asleep	O	O	O	O
Driving a car	O	O	O	O	Concentrating	O	O	O	O
Looking over shoulder	O	O	O	O	Exercising	O	O	O	O
Caring for family	O	O	O	O	Yard work	O	O	O	O

22. What is the major stressor in your life?_____ **23. How much sleep do you average per night?_____hours**

24. What is the type and approximate age of your mattress and pillow?_____ **25. What is your preferred sleeping position_____**

26. Describe your typical eating habits: **O** Skip breakfast **O** Two meals a day **O** Three meals a day **O** Snacking between meals

27. What would be the most significant thing that you could do to improve your health?_____

_____

28. In addition to the main reason for our visit today, what additional health goals do you have?_____

_____

ACKNOWLEDGEMENTS

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and Initial your agreement.

I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials_____

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on m behalf for seeking reimbursement from any involved third parties.

Initials_____

I realize that and X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY)_____

Initials_____

I grant permission to be called to confirm or reschedule an appointment between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials_____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Initials_____

If the patient is a minor child, print child's full name:_____

Signature_____ _____

Date (MM/DD/YYYY)

_____

Patient Name

_____

Patient Number
(office use only)

_____

Doctor's Initials