UprightHealth
MUSCLE & JOINT CARE

General Information

Patient Name:________________________________

Date of Birth:________________________________

Address:________________________________

City:________________________________

State:______________ Zip:________________

E-mail:________________________________

Phone:____________________ ☐ Cell ☐ Home

Occupation:________________________________

Employer:________________________________

How did you hear about/find us?____________________

____

Is this your first visit to a Chiropractic Physician?

☐ No ☐ Yes

Emergency Contact Info

Name:________________________________

Relationship:________________________________

Phone:____________________ ☐ Cell ☐ Home

Dr.'s Notes

Reason for Visit

What brings you in today?____________________

____

Have you received treatment for this condition in the past?

☐ No ☐ Yes

If yes, where?________________________________

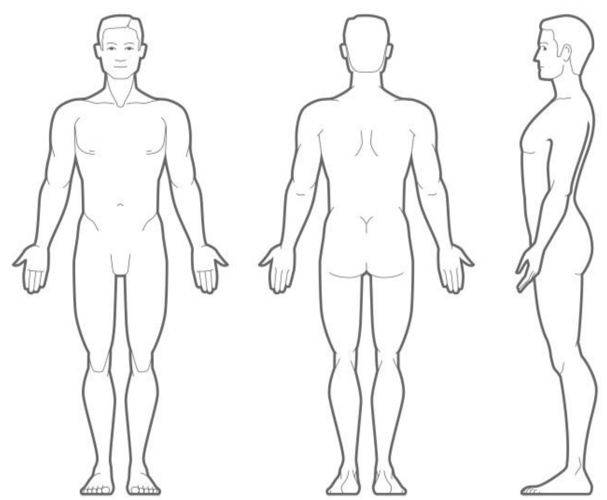
When?________________________________

Are you seeking treatment related to an accident?

☐ Auto ☐ Work ☐ Other ☐ No

Using the symbols below, please mark any areas where you're experiencing:

× Pain ⊘ Numbness or Tingling # Burning



How severe is your pain on a scale of 0 to 10:

On Average?______ At worst?________ At best?_______

Check the boxes that best describe your symptoms:

☐ Constant ☐ Comes & goes ☐ Worse at night
☐ Worse in the morning ☐ Sharp ☐ Dull
☐ Aching ☐ Shooting ☐ Throbbing

When did your symptoms first appear?________________

____

What (if anything) makes it better?________________

____

What makes it worse or irritates it?________________

____

Health History

Recent signs & symptoms: (Please check all that apply.)

- ☐ Constant Pain
- ☐ Unexplained Weight Loss/Gain
- ☐ Loss of Bladder Control
- ☐ Abnormal Bleeding
- ☐ Fatigue
- ☐ Excessive Thirst
- ☐ Frequent/Painful Urination
- ☐ Excessive Bruising
- ☐ Fever, Chills, Sweats
- ☐ Nausea/Vomiting
- ☐ Blood in Urine
- ☐ Difficulty Breathing
- ☐ Change in Appetite
- ☐ Severe Abdominal Pain
- ☐ Black/Bloody Stools
- ☐ Tightness in Chest

Are you currently pregnant? ☐ No ☐ Yes, Due Date:________________

Have you ever had any of the following conditions?

- ☐ Cancer
- ☐ Hypertension
- ☐ Recurring Sinusitis
- ☐ Disc Herniation/Bulge
- ☐ Anemia
- ☐ Pacemaker
- ☐ Bloating
- ☐ Arthritis
- ☐ Bleeding Disorder
- ☐ Stroke
- ☐ Belching/Gas
- ☐ Osteoporosis
- ☐ Bruise Easily
- ☐ Swelling in Ankles/Legs
- ☐ Kidney Disease
- ☐ Rheumatoid Arthritis
- ☐ Clotting Disorder
- ☐ Allergies
- ☐ Anxiety
- ☐ Latex Allergy
- ☐ Cardiovascular Disease
- ☐ Glaucoma
- ☐ Depression
- ☐ Psoriasis
- ☐ Heart Attack
- ☐ Recurring Ear Infections
- ☐ Drug/Alcohol Dependency
- ☐ Sprained Ankle

Please list any injuries, hospitalizations or surgeries, with approximate dates: (broken bones, appendicitis, etc…)

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____

____

Medications	Vitamins	Allergies

Dr.'s Notes

Lifestyle

Exercise

- ☐ None
- ☐ Minimal
- ☐ Moderate
- ☐ Daily
- ☐ Excessive

Work Activity

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Medium Labor
- ☐ Heavy Labor

Habits

- ☐ Smoking Frequency: ________________
- ☐ Alcohol Frequency: ________________
- ☐ Recreational Drugs Type: ____________________
- ☐ Coffee/Caffeine Frequency: ________________
- ☐ High Stress Reason: __________________

Nutrition

How would you describe your eating habits?

- ☐ I eat whatever and whenever I want.
- ☐ I make an attempt to eat right, but struggle.
- ☐ Most of the time I eat right, but treat myself on occasion.
- ☐ I strictly regulate my food intake, all the time.
- ☐ I'm all over the board. No consistency

Sleep

Average hours of sleep per night?__________________

I normally sleep on my:

☐ Back ☐ Stomach ☐ Side ☐ Toss & Turn

Authorization to Provide Care

I authorize the physicians at Upright Health Muscle & Joint Care to administer manual manipulations, advanced soft tissues techniques, passive therapies and/or any treatment they deem appropriate, for the purposes of regaining and/or maintaining musculoskeletal health, unless I expressly refuse beforehand.

Initial:_________

Receipt of Notice of Privacy Practices

I have been offered a copy of Upright Health Muscle & Joint Care's Notice of Privacy Practices, which provides an explanation of my rights with respect to my personal health information and the privacy practices of this clinic, in accordance with the Health Insurance Portability & Accountability Act (HIPAA) of 1996. I understand I can review this notice anytime at www.uprighthealth.us/npp.pdf

Initial:_________

Payment Policy

I understand that payment for services rendered, per the fee schedule listed at http://uprighthealth.us, will be due on the date of service and accepted in the forms of cash, check or charge. I may choose to submit a reimbursement claim directly to my insurance provider. UprightHealth will supply any additional documentation regarding my treatment, needed for this purpose, at my request.

Initial:_________