We Care Chiropractic, PC

20100 N. 51st Avenue, Suite B210, Glendale, AZ 85308 (623) 825-4444
Neil T. Dende, D.C

CONFIDENTIAL INFORMATION[1]

The following information is needed for our files so we can better serve you as a patient. PLEASE FILL THID FORM OUT COMPLETELY; DO NOT LEAVE ANY BLANKS (MARK N/A). If you need any assistance, please ask the receptionist.

PATIENT DATA:

NAME:_____DOB: _____SS: _____-_____-_____
ADDRESS:_____ CITY:_____STATE:_____ZIP: _____
PHONE: (H)_____ (W)_____ (C)_____
EMAIL ADDRESS: _____

OCCUPATION: _____ EMPLOYER: _____
SPOUSE NAME: _____ SPOUSE EMPLOYER_____
SPOUSE PHONE: (W) _____ (M) _____

Name and Telephone number of person to contact in case of an emergency:
_____

INSURANCE INFORMATION:
If no insurance, please skip this section and mark here:_____.

PRIMARY INSURANCE CO. _____
ID # _____ GROUP # _____
POLICY HOLDER'S NAME:_____ DOB: _____

SECONDARY INSURANCE CO. _____
ID # _____ GROUP # _____
POLICY HOLDER'S NAME:_____ DOB: _____

HOW WERE YOU REFERRED TO OUR OFFICE? (PLEASE CHECK)

☐ FRIEND REFERRAL NAME: _____
☐ YELP
☐ INSURANCE PLAN DOCTOR LIST
☐ GENERAL INTERNET SEARCH
☐ SMART PHONE SEARCH FOR NEARBY DOCTOR
☐ PHYSICIAN NAME OF PHYSICIAN: _____

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PERSONAL DATA

HEIGHT: _____ WEIGHT: _____ AGE: _____

(CIRCLE ONE) LEFT HANDED RIGHT HANDED BOTH

(CIRCLE ONE) MARRIED SINGLE DIVORCED WIDOWED SEPARATED

EXERCISE: ☐ DAILY ☐ REGULARLY ☐ SOMETIMES ☐ NEVER

DO YOU DRINK ALCOHOL? IF SO, HOW MANY DRINKS PER WEEK? _____

DO YOU SMOKE SIGARETTES? IF SO, HOW MANY PER DAY?_____

HAVE YOU EVER HAD CANCER? _____ IF SO, PLEASE EXPLAIN_____

_____

FAMILY HISTROY: This is very important, so please fill this out as complete as possible. I am interested in knowing if any health conditions run in your family which may affect you.

MOTHER: If living, what is her age? _____ health condition: _____
If deceased, what was the cause?_____

Does she have any diagnosed health conditions such as diabetes, heart trouble, headaches, thyroid problems, etc?_____

FATHER: If living, what is his age? _____ health condition: _____
If deceased, what was the cause?_____

Does he have any diagnosed health conditions such as diabetes, heart trouble, headaches, thyroid problems, etc?_____

BROTHERS/SISTERS: (LIST ALL) Please list any kind of health condition they have

1. Age: _____ Health Problem: _____ Brother or Sister
2. Age: _____ Health Problem: _____ Brother or Sister
3. Age: _____ Health Problem: _____ Brother or Sister
4. Age: _____ Health Problem: _____ Brother or Sister

If any siblings are deceased, please list the cause of death and what age:

_____

If any other conditions have been known in other family members not listed, please explain:

_____

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GENERAL HEALTH SCREENING

Have you had the flu or a fever recently? _____ Currently?_____
Weight loss without intentionaly dieting? _____

Do you ever have any type of chest pain, arm pain, throat pain or loss of breath?_____
If so, which ones? _____

Date of your last physical examination? _____
List ANY operations (major or minor) which you have had in your lifetime:_____
_____

Serious illness? (please list all): _____

List medication (over the counter or presciption) which you currently take: _____
_____
List any controlled substance(s) that you use: _____

ALL OF THE INFORMATION CONTAINED IN THIS PACKET IS CONFIDENTIAL AND WILL REMAIN AS MUCH.

PRIMARY COMPLAINT:
What is the primary complain you want evaluated today? _____
Describe cause of pain: _____

How long has the current pain episode been going on? _____
Have you had similar pain before? Y / N If so, when was the last episode? _____

Have you seen any other dotor for this complaint recently? Y / N If so, doctor name: _____

Have you had past treatment for this condition (circle one)
None Family doctor Chiropractor Physical Therapy Acupuncture
Pain specialist (please explain):_____
_____
Prior surgery? _____

SECONDARY COMPLAINTS
What other complaints would you like evaluated today? _____
_____
_____
_____

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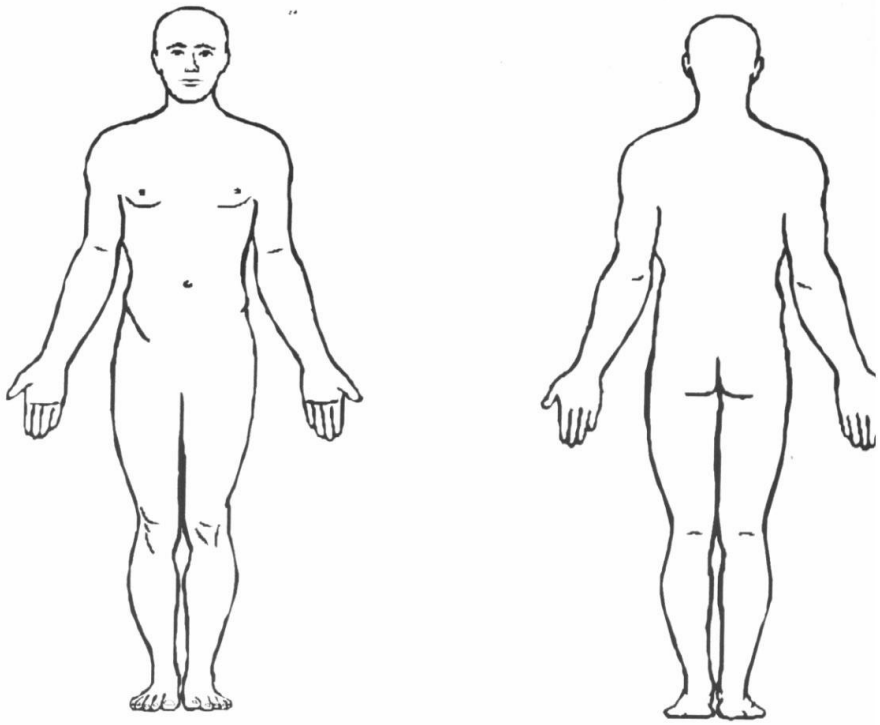
PAIN CHART

PLEASE MARK THE FIGURE BELOW USING THE SENSATION KEY TO INDICATE THE TYPE OF PAIN YOU HAVE:

SENSATION KEY:	ACHE	BURNING	NUMBNESS	PINS/NEEDLES	STABBING	OTHER
	ΔΔΔΔ	//////////////////	++++++++++	==========	XXXXXXX	◊◊◊◊◊◊

FRONT **BACK**



A. Circle the number (on the 0-10 scale) to indicate your CURRENT pain level:
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (AS BAD AS POSSIBLE)

B. Circle the number (on the 0-10 scale) to indicate your AVERAGE pain level:
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (AS BAD AS POSSIBLE)

C. Circle the number (on the 0-10 scale) to indicate your WORSE pain level:
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (AS BAD AS POSSIBLE)

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PLEASE CHECK THE DISORDERS WHICH APPLY TO YOU

GENERAL
___Recent weight change
___Weakness
___Fatigue
___Insomnia
___Sinus problems
___Indigestion

MOUTH
___Bleeding gums
___Sore gums
___Mouth sores

GU
___Increased frequency in urination
___Hesitancy of urination
___Kidney stones
___Past urinary infections
___Increased urgency in urination
___Leaking before or after urintation
___Burning with or after urination
___Brown urine

VASCULAR
___Varicose veins
___Cramping in legs, arms, etc
___Thrombophlebitis

PSYCHIATRIC
___Mood swings
___Depression
___Frequent crying
___Panic attacks
___Anxiety
___Any diagnosed mental or depression conditions?
_____
_____
_____

SKIN
___Rash
___Lumps
___Change in hair or nails

EARS
___Ringing in ears
___Loss of hearing
___Vertigo (spinning)
___Lightheadedness
___Ear infections

GI
___Burping stomach acids
___Black stools
___Frequent burping
___Excessive gas
___Diarrhea
___Constipation
___Rectal bleeding
___Food intolerance
___Hemorrhoids

NEUROLOGIC
___Seizures
___Fainting or blackouts
___Tremors
___Memory loss
___Numbness
___Weakness of (circle) Leg Arm Hand

ENDOCRINE
___Heat or cold intolerance
___Excessive sweating
___Diabetes
___Excessive thrist
___Brown urine

HEAD
___Migraine headaches
___Cluster headaches
___Tension headaches
___Sinus headaches
___Visual disturbances w/headaches
___Nausea w/headaches
___Vomiting w/headaches

CHEST/CARDIAC
___Thoat pain or restriction
___Chest pain or discomfort
___Shortness of breath
___High blood pressure
___Childhood rheumatic fever
___Heart murmer
___Irregular heart beat
___Swelling (circle) Ankles Hands

REPRODUCTIVE
___Pre-menstrul syndrome
___Bleeding between periods
___Excessive cramping
___Menopausal symptoms
___What age did menopause begin?_____
___Currently pregnant? _____
___Miscarriage(s)_____
___Date of last menses_____

By affixing my signature below, I do hereby declare that I have examined this report and to the best of my knowledge and believe it is true, correct and complete.

PATIENT SIGNATURE_____**DATE** _____