Stones River Chiropractic

Adult History Form

206 N Thompson Lane, Suite B
Murfreesboro, TN 37129
615-867-6700

Name _____ Date _____ File _____

Date of Birth _____Age _____ Social Security# _____ Sex - M F Married Single Other

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Occupation _____ Employer _____

Who may we thank for referring you? _____

HISTORY OF COMPLAINT

What brings you in today? Primary_____

Secondary _____ Third _____

For second and third concerns, please get an additional form

When did this begin? _____ Was this onset - *Gradual Sudden*

Did something cause this? _____

Is this problem - *Constant Comes & Goes* Is it getting - *Better Worse Same*

Have you had this problem before? *Yes No* If yes, when _____

Is this related to an accident? *Yes No* If yes, was it- Auto Work Other_____

Does the pain travel to any other area? *Yes No* If yes, where _____

When does it feel the worst? *A.M. Midday P.M.* Other _____

What makes it - Better _____

Worse _____

Any numbness, tingling or weakness in your extremeties? _____

Any change or loss in bowel or bladder habits? _____

Have you seen someone for this condition? _____

Prior diagnosis? _____ Prior treatment? _____

Please MARK the areas where you have pain or other symptoms

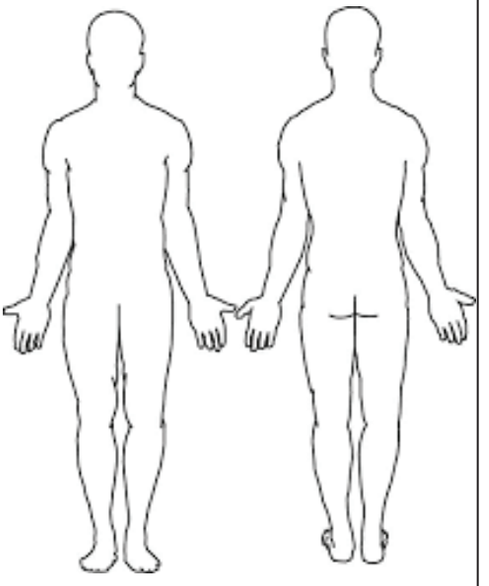
How intense are your symptoms AT WORST
0-No symptoms 10-Severe symptoms
0 1 2 3 4 5 6 7 8 9 10

How intense are your symptoms AT BEST
0 1 2 3 4 5 6 7 8 9 10

How would you describe it

Sharp Stabbing Throbbing Shooting
Achy Cramping Numbness Tingling
Dull Other _____

What percent of the time does this a bother
0% 25% 50% 75% 100%



Doctor's Area

HEALTH & ILLNESS HISTORY - Please CIRCLE any condition that you have or have had

Anxiety	Circulation Issues	Heartburn	Scoliosis
Arteriosclerosis	Childhood Illness	Hepatitis	Sinus Problems
Asthma	Depression	Immune Issues	Stroke
Allergies	Diabetes	Lymphatic Issues	TMJ Issues
Back Pain	Digestive Issues	Multiple Sclerosis	Urinary Issues
Cardiovascular	Frequent Colds	Neck Pain	Osteoporosis
Cancer	Headaches/Migraines	Reproductive Issues	Other _____
Carpal Tunnel	Heart Disease	Ringing in Ears	_____

FAMILY HISTORY - Please CIRCLE any condition that you have family history of

Cancer Heart Disease Diabetes Stroke Other _____
Relationship _____

INJURIES, ILLNESSES, SURGERIES

Auto Accidents _____

Injuries, Dislocations or Fractures _____

Illnesses_____

Surgeries_____

ALLERGIES, MEDICATIONS, SUPPLEMENTS

Allergies_____

Medications_____

Supplements_____

How many ounces of water to you drink on average each daily? _____

What are your goals

Immediate _____

Short term _____

Long term _____

Have you experienced chiropractic before? *Yes* *No* If yes, was your experience - *positive* *negative* *neutral*

ASSIGNMENT, AUTHORIZATION AND FINANCIAL AGREEMENT

I hereby consent to a chiropractic evaluation and examination, x-ray(s) and chiropractic treatment rendered to the patient by the doctors at Stones River Chiropractic. I hereby assign and authorize payment of insurance benefits directly to Stones River Chiropractic. I authorize Stones River Chiropractic to release information requested on this form, as well as, release of any and all medical records or other information necessary to obtain payment. I understand that I am responsible for payment of my account.

*Signature*_____ *Date*_____

*Printed Name*_____ *Relationship to Patient*_____

HIPAA

Health Insurance Portability and Accountability Act was passed to protect your Personal Health Information. Compliance with HIPAA is mandatory. Sign below to acknowledge that you have received and reviewed the HIPAA policy at our office, Stones RIver Chiropractic, that all questions have been answered and that you have had the opportunity to receive a copy.

*Signature*_____ *Date*_____

*Printed Name*_____ *Relationship to Patient*_____