RHINO CHIROPRACTIC & Holistic Wellness Center

Date: ___/____/_____

Patient: _____ Birthdate: ____/____/_____ Age: _____ Sex: ☐M ☐F

Address: _____City: _____State:_____ Zip: _____

Home Phone: _____ Cell Phone: _____SS#_____ _____

Email: _____Occupation: _____

Employer: _____Employer Address: _____City _____ Zip _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Spouse's Name_____

Number of Children: _____ Whom may we thank for referring you? _____

Primary reason for your visit:_____

How did this occur? _____

Symptoms Appeared: ☐ Gradually ☐ Suddenly

How long have you had this pain? _____Days/Weeks/Months/Years

Mark an X on the picture where you are having discomfort ⟶

Type of Pain:☐Aching ☐Burning ☐Diffused ☐Numbness ☐Dull

☐Sharp ☐Shooting ☐Throbbing ☐Tightness ☐Tingling

How frequently do you have this pain? Constant Frequent Intermittent Occasional

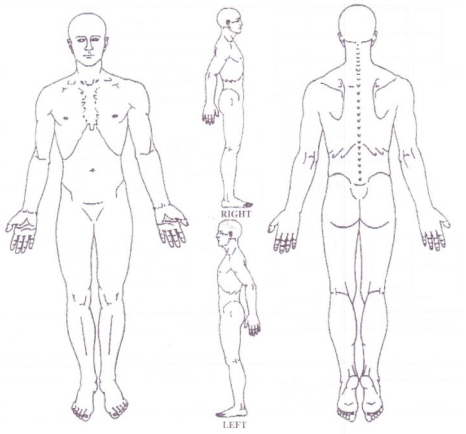
Symptoms are aggravated by: _____

Symptoms are reduced by: _____

Rate the severity of your pain (circle one): 1 2 3 4 5 6 7 8 9 10

What time of day is the pain most noticeable? _____

Mark an X on the picture where you are having discomfort



Please list any other pain, health problems, symptoms, and/or complaints in order of severity.

1. _____For how long? _____
2. _____For how long?_____
3. _____For how long?_____

Has this problem been getting worse or staying the same? _____

Currently or in the past have you ever experienced any of these complaints while working? ☐ Yes ☐No

If yes, please describe what activities at work may be causing you to experience these complaints:

_____

Are there any other activities, incidents, or events outside of work that may have caused these complaints? ☐Yes ☐ No

If yes, please explain: _____

What treatment have you already received for your condition? ☐None ☐Surgery Date(s):_____

☐ Physical Therapy Date(s): _____ ☐Chiropractic Services Date(s): _____

Name and address of other doctor(s) who have treated you for your condition: _____

Have you ever had any surgeries or hospitalizations? ☐Yes ☐No If yes, please list dates: _____

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Is this condition due to an accident? ☐Yes ☐No Type of accident: ☐Auto ☐Work ☐Home ☐Other Injury Date: _____

To whom have you made a report of your accident? ☐Auto insurance ☐Employer ☐Worker's Comp Other _____

If auto accident, were you the driver? ☐ Yes ☐ No How many passengers were in the car with you? _____

Auto/Work Comp Insurance Company: _____ Phone #: _____

Policy #: _____Claim #: _____ Attorney's Name: _____

Check off all medications you are currently taking: ☐ Pain ☐ Blood Pressure ☐Cholesterol ☐Diabetes ☐Anti-Inflammatory

☐ Allergy ☐ Heartburn ☐ Thyroid ☐ Anxiety ☐ Mood Stabilizing ☐ Sleeping Pill ☐ Birth Control ☐ Blood Thinner ☐ Antibiotics

☐ Gastrointestinal ☐ Asthma Other: _____

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, **PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.**

0 means no disability at all, and a score of **10** means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing)

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.) _____

2. RECREATION: hobbies, sports and other similar leisure time activities _____

3. SOCIAL ACTIVITY: activities which in volve participation with friends and acquaintances other than family members Including parties, theater, concerts, dining out and other social functions. _____

4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. _____

5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc) _____

6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing. _____

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered
2. Copies of films can be furnished for a $25 charge/film. Payment must be received prior to copying. Allow 5-7 business days.
3. Films may be loaned to another health provider with prior authorization and a $50 refundable cash deposit. _____**Initials**

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ policy #_____ and assign directly to Dr. Gehnrich all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ Responsible party signature

_____ Relationship to patient

_____ Date

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Please list and describe all traumas that have occurred in your lifetime. Include dates and your age at the time if applicable. Please be as thorough as possible.

Physical		**Emotional**		**Chemical**	
Ex: Sports injuries, car accidents, falls, bad posture, surgeries		**Ex: Types of stress: work, family, financial, kids, health, life**		**Ex: Medications, poor diet, processed foods, environmental toxins, smoking**	

Please check all conditions below that you currently have or have had in the past

☐AIDS/HIV	☐Chicken Pox	☐Heartburn/Acid reflux	☐Menstrual Irregularities	☐Prostate Problems
☐Alcoholism	☐Chemical Dependency	☐Heart Disease	☐Migraine Headaches	☐Prosthesis
☐Allergies	☐Constipation	☐Heart Palpitations	☐Miscarriage	☐Rheumatoid Arthritis
☐Allergy Shots	☐Depression	☐Hepatitis	☐Mononucleosis	☐Ringing in the Ears
☐Anemia	☐Diabetes	☐Hernia	☐Multiple Sclerosis	☐Sinusitis
☐Appendicitis	☐Diarrhea	☐Herniated Disc	☐Mumps	☐Sleeping Problems
☐Arthritis	☐Difficulty Swallowing	☐Herpes	☐Nervousness/Anxiety	☐Thyroid Problems
☐Asthma/Short of breath	☐Dizziness	☐High Blood Pressure	☐Osteoporosis	☐Tonsillitis
☐Bleeding Disorder	☐Eating Disorder	☐High Cholesterol	☐Pacemaker	☐Tuberculosis
☐Breast Lump	☐Emphysema	☐IBS	☐Parkinson's Disease	☐Tumors/Growths
☐Bronchitis	☐Epilepsy	☐Kidney Disease	☐Pinched Nerve	☐Ulcers
☐Cancer	☐Glaucoma	☐Liver Disease	☐Pneumonia	☐Upset Stomach
☐Cataracts	☐Headaches	☐Measles	☐Polio	☐Vaginal Infections

Any other conditions not listed above: _____

I _____ certify that the information presented to Rhino Chiropractic in this form is true, complete, and correct to the best of my knowledge.

_____ _____

Signature Date