Desert Mountain
CHIROPRACTIC

21321 East Ocotillo Road #121 ● Queen Creek, AZ
Phone: 480.987.9740 ● Fax: 480.457.1165 ● www.dmchiropractic.com

Today's Date _____

Name _____ ☐ Male ☐Female
Last First Middle

Address _____ _____
Street City State ZIP

Birth Date _____ Age _____ SSN _____-_____-_____

Home Telephone Number _____ Cell Phone Number _____

Email Address _____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Employment Status: ☐Employed ☐Student ☐Homemaker ☐Retired

Occupation _____ Employer _____ Phone _____

RESPONSIBLE PARTY INFORMATION

Name (Guarantor) _____ Date of Birth_____

Relationship to Patient _____ Telephone Number _____

Address _____

Insurance_____ ID # _____ Group # _____ Claim # _____

HOW WERE YOU REFERRED TO THIS OFFICE? ☐Insurance Directory ☐Attorney ☐Doctor
☐Internet search/website ☐Phone book ☐Mailer ☐Sign
☐Patient Referral (Name of source)_____ ☐Other_____

WHO IS YOUR PRIMARY CARE PHYSICIAN IF APPLICABLE? Name: _____
Clinic:_____
City:_____

Is your condition related to any of the following? ☐Work injury ☐Auto accident

PATIENT FINANCIAL AGREEMENT & ASSIGNMENT OF BENEFITS

I, the undersigned, authorize the release of any information including diagnosis and the records of any treatment rendered to me or those I am responsible for during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Desert Mountain Chiropractic all medical benefits, if any, otherwise payable for service rendered. **I agree to pay all charges for medical and health care services not covered by my insurance company.** I authorize the use of this signature on all my insurance submissions and to obtain records.

CANCELLATION POLICY

As a courtesy to other patients waiting to see the doctor or therapist, we ask that you give 24 hours notice for any cancelled appointments. In the event of an emergency, please contact the office as soon as possible so that your appointment time may be given to another patient. Due to the fact that our massage therapists are paid on a per massage basis, we reserve the right to apply a **$35 missed appointment fee** to your account for failure to provide timely notice of any changes to your appointment(s).

I certify that I have read this form and understand its content.

Patient/Legal Guardian Signature _____ Date _____

CHIEF COMPLAINT / PATIENT HISTORY

1. Describe your condition/symptoms: _____

2. How long have you had your condition? _____ **3. What caused your condition?** _____

4. How often do you experience your symptoms?

□**Constantly** (76-100% of the time) □**Frequently** (51-75% of the time) □**Occasionally** (26-50% of the time) □**Intermittently** (1-25% of the time)

5. How would you describe the type of pain?

□ Sharp □ Numb / Tingly □ Dull / Achy □ Stiff □ Burning □ Sharp / Stabbing with motion
□ Shooting □ Shooting with motion □ Pressure □ Radiating □ Other:_____

6. How are your symptoms changing with time? □ Getting Worse □ Staying the Same □ Getting Better

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem? 0 1 2 3 4 5 6 7 8 9 10 (Please circle)

8. How much has the problem interfered with your work? □ Not at all □ A little □ Moderately □ Quite a bit □ Extremely

9. How much has the problem interfered with your social life/sleep? □Not at all □A little □Moderately □Quite a bit □Extremely

10. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER physician □ Orthopedist
□ Massage Therapist □ Physical Therapist □ No one □ Other:_____

11. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

12. What aggravates your problem?_____

13. What concerns you the most about your problem; what does it prevent you from doing?_____

14. What have you done/taken that has helped your condition?_____

15. List any prescription / over-the-counter medications you are currently taking._____

16. List any vitamins/herbs/supplements that you are currently taking._____

17. List all surgical procedures you've had: _____

18. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past Present	Past Present	Past Present	Past Present
□ □ Headaches	□ □ High Blood Pressure	□ □ Diabetes	□ □ General Fatigue
□ □ Neck Pain	□ □ Heart Attack	□ □ Excessive Thirst	□ □ Loss of Appetite
□ □ Back Pain	□ □ Chest Pains	□ □ Frequent Urination	□ □ Asthma
□ □ Sciatic pain	□ □ Stroke	□ □ Smoking/Tobacco Use	□ □ Chronic Sinusitis
□ □ Shoulder Pain	□ □ Jaw Pain	□ □ Drug/Alcohol Dependance	□ □ Dizziness
□ □ Elbow Pain	□ □ Kidney Stones	□ □ Allergies	□ □ Visual Disturbances
□ □ Wrist Pain	□ □ Painful Urination	□ □ Depression	□ □ Other:_____
□ □ Hand Pain	□ □ Incontinence	□ □ Systemic Lupus	For Females Only
□ □ Hip Pain	□ □ Abdominal Pain	□ □ Epilepsy	□ □ Birth Control Pills
□ □ Knee Pain	□ □ Arthritis	□ □ Cancer	□ □ Hormonal Replacement
□ □ Ankle/Foot Pain	□ □ Rheumatoid Arthritis	□ □ HIV/AIDS	□ □ Pregnancy
	□ □ Fever	□ □ Abnormal Weight Gain/Loss	

19. What activities do you do at work?

□ Sit:	□ Most of the day	□ Half the day	□ A little of the day
□ Stand:	□ Most of the day	□ Half the day	□ A little of the day
□ Computer work:	□ Most of the day	□ Half the day	□ A little of the day
□ On the phone:	□ Most of the day	□ Half of the day	□ A little of the day
□ Driving:	□ Most of the day	□ Half of the day	□ A little of the day

20. What is your: Height_____ **Weight** _____ **Date of Birth** _____**Occupation** _____

21. What activities do you do outside of work?_____

22. Have you ever been hospitalized? □No □Yes **If yes, why?** _____

23. Have you had significant past trauma? □No □Yes **If yes, describe**_____

24. Have you been to a chiropractor before? □No □Yes **If yes, how long ago?**_____ **What were your results?**_____

25. Anything else pertinent to your visit today? □ No □ Yes **If yes, explain**_____

HABITS	None	Light	Moderate	Heavy
Exercise	□	□	□	□
Alcohol	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□

Patient Signature_____ **Date**_____