Skinner Chiropractic/Southside Chiropractic/Skinner Wellness

3198 Custer Dr. Ste 100
Lexington, KY 40517

Patient Name_____ Date: _____
Email_____
SS #/SIN_____ DOB_____ ☐ Male ☐Female Home phone_____ Cell Phone _____
Check appropriate Box**:** ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Patient's Address _____City _____ State_____
Zip_____
Employer Name:
_____
Spouse or Patient's Guardian name_____ Spouse's Employer_____
Whom may we thank for referring you?
_____
Person to contact in case of an emergency_____
Phone_____

Responsible Party
Name of The Person responsible for this account _____ Relationship to Patient_____
Address _____ Home Phone_____
E-Mail _____ Cell Phone _____
Driver's License # _____ Date of Birth: _____
Is the person currently a patient at our office? ☐ Yes ☐ No

Do you have any Medical insurance? ☐ Yes ☐ No if yes, complete the following:
Name of the insured_____ Relationship to patient_____
Birthdate_____ SS#/SIN_____ Name of Employer_____ Work Phone _____
Address of Employer_____ State _____
Zip_____
Insurance Company_____ Group #_____ Union or local # _____
Ins. Co. Address _____ City _____ State _____
Zip_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I certify that all information is true and correct. I hereby authorize the release of any information required by this office. I also authorize my benefit payments to be made directly to this clinic. If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct my insurance company to make out the check to me and mail it to this office. I understand that I am financially responsible for all the services rendered. I agree that if my treatment here is suspended or terminated, bills become immediately due and payable. All x-rays are property of Skinner Chiropractic/Southside Chiropractic/Skinner Wellness. I authorize Skinner Chiropractic/Southside Chiropractic/Skinner Wellness to file a written formal complaint to the insurance commissioner, or Department of Labor, on my behalf. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

X_____ Patient signature

Skinner Chiropractic/South Side Chiropractic/Skinner Wellness

Patient Name: _____ DOB: _____ Date: _____

Date: _____

X_____
Patient name printed

X_____
signature of Guardian if applicable

_____ _____
Signature of Provider Date

Skinner Chiropractic/South Side Chiropractic/Skinner Wellness

Patient Name: _____ DOB: _____ Date: _____

Chief Complaint:

_____

History of Present illness:

Location:

_____
(Where is the pain/problem?)

Quality:

_____
(Example: normal vs abnormal color, activity, etc..)

Severity:

_____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration:

_____
(How long have you had this pain/ problem? When did it start?)

Timing:

_____
(Does the pain/problem occur at a specific time?)

Context:

_____
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms:

_____
(What other associated problems have you been having?)

Aggravating factors:

_____
(What makes the pain/problem worse? Have you had previous episodes?)

Relieving factors:

_____
(What makes the pain/problem better?)

Complete this section if due to an accident

Type of accident:

- Auto
- Workers Comp
- Fall
- Other: _____

Date of accident: _____

Brief description of accident:

_____
_____
_____
_____
_____

Past Medical History

Please check the box if you have had any of the following:

Measles/Mumps
Chicken pox
Whooping Cough
Scarlet Fever
Rheumatic fever
Pneumonia
Tuberculosis
If yes, last xray? _____
Asthma
Bronchitis
Anemia
Blood/Plasma Transfusion
Bleeding Tendency
Ulcer
Hepatitis
Recurrent Bladder Infection
Kidney Disease
Arthritis
Back trouble
Migraine headaches
High blood pressure
Low blood pressure
Mitral valve prolapse
Peripheral Vascular disease
Stroke
Diabetes
Thyroid Disease
Glaucoma
Cancer
Other:
_____
_____
_____
_____

Previous Hospitalizations/Surgeries/Serious Illnesses

Please include location and date

_____
_____
_____

_____
_____
_____

_____
Signature of Provider

_____
Date

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Health Screenings:

Last pap:	Last colonoscopy:	Last pneumonia shot:
Last mammogram:	Last PSA/DRE:	Last tetanus shot:
Last bone density:	Last Flu shot:	

_____ _____

Signature of Provider Date

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Patient Name: _____ DOB: _____ Date: _____

Allergies:

_____

_____

Medications: (include nonprescription)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Social History:

Occupation:

_____

Marital Status: M S W D

Alcohol Use: Never: ___ Rarely: ___ Moderate: ___

Daily: ___

Type:

_____

Tobacco Use: Never: ___ Current: _____ packs per day x ____ yrs Former: ____ packs per day x ___ yrs

Use of Drugs Never: ___

Type/Frequency:

_____

Excessive Exposure at home or at work to: Fumes: _____ Dust: _____ Solvents: _____

Airborne Particles: _____ Noise: _____

Family Medical History:

	Age	Disease	If deceased, cause of death
Mother			
Father			
Brother			
Sister			
Children			
Other			

Review of Systems (Check here ☐ if no symptoms to report)

Please check the box if you have had any of the following in the past 1-2 months

Asthma		
Stuffy nose	Irritability	Migraines
Hay fever		
Sore throat	Constipation	Dizziness
Chronic cough		
Chest congestion	Diarrhea	Numbness
Frequent sneezing		
Itchy/watery Eyes	Burning with urination	Tinging
Sinus drainage		
Earache/ear infection	Blood in urine	Pins/needles in hands/feet
Shortness of breath		
Wheezing	Blood in stool	Muscle aches
Chest pain		
Fatigue	Feeling foggy	Joint pain
Malaise		
Weakness/tiredness	Forgetfulness	Low back pain
Lightheadedness		
	Headaches	Neck pain

_____ _____

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Patient Name: _____ DOB: _____ Date: _____

Wrist/hand pain

Hip pain

Ankle/foot pain

Elbow pain

Pain between shoulder blades

Knee pain

Shoulder pain

_____ _____

Signature of Provider Date