Spring Lake Chiropractic

2022 State Route 71, Suite 101 Spring Lake Heights NL 07762

Dr. Jeffrey M. Fitch

Chiropractic – Acupuncture – Yoga – Core Rehab -Massage – Reiki -Thai Massage -Meditation

Please allow us to photocopy your insurance details. All information you supply is confidential. We comply with all federal privacy standards.

Date__/__/____

Have you consulted a Chiropractic Doctor before? Y N

Whom may we thank for referring you? _____

Your

Name_____ email _____

Address_____ City_____ Zip _____

Cell # _____ Home # _____ Work # _____

Indicate best or preferred method of contact: text voice email

Age_____ DOB_____ Marital Status_____ Gender_____ SS#_____

Emergency contact name and # _____

Primary Care Provider Name _____

Your Employer _____

Insurance Carrier_____ ID# _____ Group# _____

Insured Name _____ DOB_____

INT____I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non covered services I receive.

INT_____I authorize Dr. Fitch to perform history, examination and treatment, that in his professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care delivered in this practice is based on the best available evidence. Further, I understand that, as in the practice of medicine, in the practice of chiropractic there may be some risks to treatment including, but not limited to, fractures, disc injury, dislocation, sprains. Every effort will be made to explain benefits and risks for each individual. I understand Dr. Fitch will use his hands or a mechanical device on my body to adjust spinal and extraspinal joints, which may result in an audible sound. It is my intent to rely on the doctor to exercise professional judgement during the course of any procedure, which he feels at the time to be in my best interest. Communication is key to any relationship. This office is always available to answer your questions.

INT____I may request a copy of the Privacy Policy and understand it describes how my personal information is protected and released on my behalf for seeking reimbursement from any involved third parties.

INT____I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office.

Patient Health Questionnaire

Patient Name_____ Date_____

When did your symptoms begin: _____

Describe Symptoms: _____

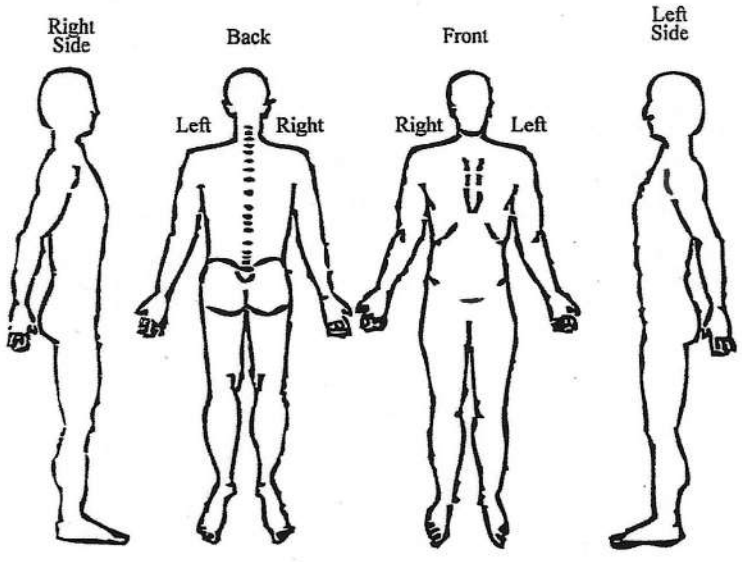
How often do you feel symptoms?

Constant (76 - 100% of the day)

Frequent (51 - 75% of the day)

Intermediate (26 - 50%of the day)

Occasional (0 - 25% of the day)



Describe Pain:

Sharp Shooting

Dull Ache Burning

Numb Tingling

Are symptoms changing?

Getting Better Not changing Getting Worse

Pain scale: 0 1 2 3 4 5 6 7 8 9 10

Mild, forgotten with activity — Moderate, significant Impact to daily living — Severe to intolerable

What activities of daily living (ADL) do you find difficult with this pain? _____

What activities do you feel less pain? _____

Who have you consulted? MD PT Massage Acupuncture DC Other

Have you ever received x rays, scans, MRI's for this condition? Yes No Where: _____

Have you experienced similar symptoms in the past? Yes No Where: _____

Do you exercise on a consistent basis? Yes No

Do you have broken bones, suffered a blow to the head, motor vehicle collision, injured in sports? Yes No

During the course of your day do you work on computer, sit for majority of the day, commute greater than 30 minutes, perform heavy lifting, perform repetitive movements? Yes No

Do you smoke? Yes No

Does your weight fluctuate up or down? Yes No

Do you feel excessive stress may be contributing to this condition and pain? Yes No

Your Height: _____ Your Weight: _____

Please provide your assessment regarding how your pain impacts the folllowing activities of daily living (ADL).

Activity	Does Not Hurt 0	Hurts A Little 1	Hurts Very Much 2	Almost Unbearable 3	Intolerable 4
Walking					
Sitting					
Standing					
Sit To Stand					
Bending					
Sleeping					
Turning In Bed					
Lifting					
Carrying					
Running/Jogging					
Pushing/Pulling					
Driving					
Turning Head					
Getting In & Out Car					
Shower / Bathing					
Reading					
Computer					
Household Chores					
Yard Work / Gardening					
Sports / Exercise					
Reaching Overhead					
Employment					
Dressing					
Watching TV					

Print Name _____ Signature _____

Examiner _____ Date _____

Score _____(0 - 96)

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please indicate any condition that you've had in the past (P) or currently have (C).

Musculoskeletal		Neurological		Cardiovascular	
Osteoporosis	P C	Anxiety	P C	High Blood Pressure	P C
Arthritis	P C	Depression	P C	Low Blood Pressure	P C
Scoliosis	P C	Headache	P C	High Cholesterol	P C
Neck Pain	P C	Dizziness	P C	Circulation	P C
Back Pain	P C	Pins / Needles	P C	Angina	P C
Hip / Knee	P C	Numbness	P C	Bruising	P C
Foot / Ankle	P C				
Shoulder	P C	Respiratory		Digestive	
Elbow	P C	Asthma	P C	Anorexia / Bulimia	P C
TMJ	P C	Apnea	P C	Ulcer	P C
Poor Posture	P C	Emphysema	P C	Food Sensitivities	P C
		Hay Fever	P C	Heartburn	P C
Illness		Shortness Of Breath	P C	Constipation	P C
Cancer	P C	Pneumonia	P C	Diarrhea	P C
Diabetes	P C				
Heart	P C	Sensory		Endocrine	
		Blurred	P C	Thyroid	
Skin	P C	Ringing Ears	P C	Immune Disorder	P C
Skin Cancer	P C	Hearing Loss	P C	Hypoglycemia	P C
Psoriasis	P C	Loss Of Taste	P C	Frequent Infection	P C
Eczema	P C	Loss Of Smell	P C	Swollen Glands	P C
Acne	P C			Low Energy	P C
Hair Loss	P C				
Rash	P C	Genitourinary		Constitutional	
		Kidney Stones	P C	Fainting	P C
		Infertility	P C	Low Libido	P C
		Bedwetting	P C	Poor Appetite	P C
		Prostate	P C	Fatigue	P C
		Erectile Dysfunction	P C	Sudden Weight Loss Or Gain	P C
		PMS	P C	Weakness	P C

Please list surgeries and illnesses not listed above _____

Please list all current medications _____

Have you been, or currently the recipient of chemotherapy, radiation, or steroid treatments? Yes No

Name _____ Signature _____