PATIENT CONFIDENTIALITY FORM

IN ORDER FOR US TO BEST SERVE YOU, WE MUST, NATURALLY, HAVE ALL AVAILABLE INFORMATION REGARDING YOUR PRESENT HEALTH. PLEASE PROVIDE US WITH THE FOLLOWING:

Patient Information

Date: _____

Name: _____ Age:_____ Date of Birth: _____

Social Security No.: _____-____-_____ Email: _____

Address: _____ City/State/Zip: _____

Preferred Phone # _____ Cell / Home Work Phone: _____

May we contact you via Email? Yes / No Text? Yes / No

Marital Status: Married / Single / Divorced / Widowed Sex: Male / Female Are you pregnant? Yes / No

Employer:_____

Spouses Name:_____ Spouses Employer: _____

Children(s) Ages:_____

Emergency Contact: _____

Relationship:_____ Phone: _____

Who or What Source Referred You:_____

Ethnicity: Hispanic or Latino/Other Preferred Language: _____

Race: Asian / African Am. Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White

Smoking Status: Every Day / Some Days / Former / Never
Education : High School / Some College /College Grad / Graduate School

Primary Care Physician: _____ Doctor's Phone: _____

May we communicate with your Primary Care Physician about your care in our office? Yes / No
Who is responsible for payment? Self / Spouse / Other Ins. Company: _____
If Other, please explain: _____

History or Current Condition

Is this related to a Work Comp. or Personal Injury Case? Yes / No

Major Complaint(s): Headache* | Neck* | Upper-Back | Mid-Back | Low Back | Other:_____
***With headache or neck pain circle all that apply: Double Vision | Difficulty Swallowing | DifficultySpeaking**
Spontaneous Falls | Dizziness | Nausea | Numbness | Rapid Eye Movement | Abnormal Gait

How did it start?_____
Previous History of Complaint Yes / No When Did it start: _____

Have you received any other treatment for this current condition? Yes / No Where? _____

How would you Rate your Pain? Mild (2 3 4) | Mod (5 6) | Sev (7 8 9) Is the Pain: Constant or Intermittent
Type of Discomfort: Sharp | Stabbing | Burning | Achy | Dull | Stiff & Sore | Numbness/Tingling
Radiating: Yes / No
Left/Right | Base of Skull | Shoulder | Arm | Hand | Hip | Leg | Knee | Foot | Ribs | Other:_____
What Makes it Better? Ice | Heat | Rest | Movement | Stretching | OTC | Prescription | Other:_____
What Makes it Worse? Sitting | Standing | Walking | Lying Down | Sleep | Overuse | Other: _____
Does Your Pain Awaken you at night? Yes / No Describe:_____

Have You Noticed any Changes in Bodily Function [Urination, Defecation, Respiration, Digestion, Vision, Sexual, other] since the onset of your complaint? Yes / No Describe:_____
Had any diagnostic testing? X-rays / MRI / CT / Other: _____

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Are you taking any medication Yes / No OTC/ Prescriptions _____

Allergies to Medications? Yes / No _____

Have you had any surgeries or broken any bones? Yes / No Please Explain: _____

Have you been diagnosed/treated for cancer? Yes / No Please Explain: _____

Have you had any new falls or accidents? Yes / No Date of fall or accident: _____

Please explain in detail how the fall or accident happened:_____

_____

Additional patient comments:_____

_____

_____

_____

_____

_____

Internal Use Only

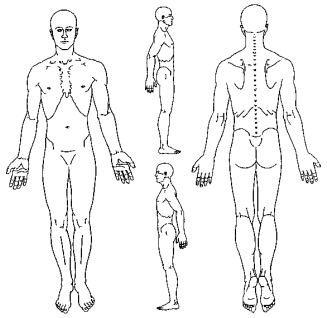
Last Visit: _____ **NP | New Incident | Re-Exam**

Patients Appearance/Mood: Distress | Mild | Moderate | Severe Nourished: Well | Obese | Morbid

Other_____

Additional Info: _____

_____



H	**__**	**Hypoesthesia**	**T**	**__**	**Tenderness upon palpation**
N	**__**	**Numb**			
P	**__**	**Pain**	**S**	**__**	**Spasm**

X-RAY ORDERED:

Cervical	Thoracic	Lumbar
3 Views	2 Views	2 Views
5 Views	4 Views	4 Views
7 Views	Flex / Ext	Flex / Ext
Oblique's		Oblique's
Flex/Ext		AP Spot

Right | Left
Hip | Knee | Ankle | Foot
Right | Left
Shoulder | Elbow | Wrist | Hand

VITALS:

HGT: _____

WGT: _____

BP: _____

Pulse: _____

TREATMENT:
Exam M A DJ X LLL

Wills Chiropractic Clinic PC
416 Valley View Dr, Suite 1300 Scottsbluff, NE 69361

CA_____DR_____

updated 4/20/20