

Triangle Spine Center's New Patient Paperwork

Date _____

First Name _____ Middle Initial ____ Last Name _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

Cell Phone (____) _____ - _____ Email _____

Date of Birth ____/____/____ Sex: Male Female

Social Security Number: _____ - _____ - _____ Marital Status: Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other _____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Contact Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

How did you hear about our office? _____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

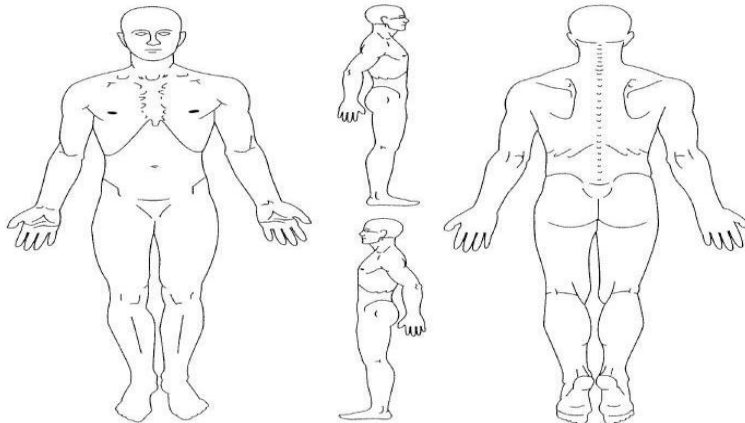
N=Numbness

B=Burning

S=Stabbing

T=Tingling

A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

How did your symptoms begin? _____

How often do you experience your symptoms?

- Constantly (76-100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Medical Conditions: _____

Surgeries: _____

Allergies: _____

Social History: (Check all that apply to you)

- Caffeine use: occasional often never
Drink Alcohol: occasional often never
Exercise: occasional often never
Cigarettes: <1 pack/day >1 pack/day never
Other _____

Family History:

Parent _____ Sibling _____
Parent _____ Sibling _____

Please list all current medications being taken _____

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____ Date _____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____

Patient's Signature _____ Date _____

Brier Creek Review of Systems

Patient Name: _____

Today's Date: _____

Please check the signs and/or symptoms related to the following body systems you now have or have experienced in the past.

CONSTITUTIONAL

- Deny All
- Chills
- Drowsiness
- Fainting
- Fatigue
- Fever
- Night Sweats
- Weakness
- Weight Gain
- Weight Loss

EYES

- Deny All
- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Double Vision
- Dry Eyes
- Eye Pain
- Field Cuts
- Glaucoma
- Sensitivity to Light
- Tearing
- Wears Glasses

CARDIOVASCULAR

- Deny All
- Angina
- Chest Pain
- Claudication
- Heart Murmur
- Heart Problems
- High Blood Pressure
- Low Blood Pressure
- Orthopnea
- Palpitations
- Shortness of Breath
- Swelling of Legs
- Varicose Veins

RESPIRATORY

- Deny All
- Asthma
- Bronchitis
- Dry Cough
- Productive Cough
- Coughing up Blood
- Difficulty Breathing
- Difficulty Sleeping
- Hemoptysis
- Pneumonia
- Sputum Production
- Wheezing

MUSCULOSKELETAL

- Deny All
- Arthritis
- Neck Pain
- Decreased Motion
- Gout
- Injuries
- Joint Pain
- Joint Stiffness
- Locking Joints
- Back Pain
- Muscle Cramps
- Muscle Pain
- Muscle Twitching
- Muscle Weakness
- Swelling

INTEGUMENTARY

- Deny All
- Breast Lumps / Pain
- Change in Nail Texture
- Change in Skin Color
- Eczema
- Hair Growth
- Hair Loss
- History of Skin Disorders
- Hives
- Itching
- Paresthesia
- Rash
- Skin Lesions

GASTROINTESTINAL

- Deny All
- Abdominal Pain
- Belching
- Black, Tarry Stools
- Constipation
- Diarrhea
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice
- Nausea
- Rectal Bleeding
- Abnormal Stool Caliber
- Abnormal Stool Color
- Abnormal Stool Consistency
- Vomiting
- Vomiting Blood

GENITOURINARY

- Deny All
- Birth Control Therapy
- Burning Urination
- Cramps
- Erectile Dysfunction
- Frequent Urination
- Hesitancy / Dribbling
- Hormone Therapy
- Irregular Menstruation
- Lack of Bladder Control
- Prostate Problems
- Urine Retention
- Vaginal Bleeding
- Vaginal Discharge

ENMT

- Deny All
- Bad Breath
- Dentures
- Deviated Septum
- Difficulty Swallowing
- Discharge
- Dry Mouth
- Ear Drainage
- Ear Pain
- Frequent Sore Throats
- Head Injury
- Hearing Loss
- Hoarseness
- Loss of Smell
- Loss of Taste
- Nasal Congestion
- Nose Bleeds
- Post Nasal Drip
- Sinus Infections
- Runny Nose
- Snoring
- Sore Throat
- Ringing in Ears
- TMJ Problems
- Ulcers

NEUROLOGICAL

- Deny All
- Change in Concentration
- Change in Memory
- Dizziness
- Headache
- Imbalance
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors

PSYCHIATRIC

- Deny All
- Agitation
- Anxiety
- Appetite Changes
- Behavioral Changes
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Homicidal Indication
- Insomnia
- Location Disorientation
- Memory Loss
- Substance Abuse
- Suicidal Indication
- Time Disorientation

ENDOCRINE

- Deny All
- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

HEMATOLOGIC / LYMPHATIC

- Deny All
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusions
- Bruise Easily
- Lymph Node Swelling

ALLERGIC / IMMUNOLOGIC

- Deny All
- History of Anaphylaxis
- Itchy Eyes
- Sneezing
- Specific Food Intolerance