Rob Chiro Inc.
3320 Peterson Rd Ste 100
Lawrence, KS 66049
p 785.843.3979
f 785.842.3979
drrobertson.medicfusion.com

Authorizations and Releases

Patient Name: ____

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time.
Initial ___

Consent to Perform and Interpret X-rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate.

I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.
Initial ___

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor and certified staff have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to a fetus.
Initial ___

Females: Consent to X-Ray During Pregnancy

This is to certify that, I am or may be pregnant and that the doctor or certified staff has my permission to perform diagnostic x-rays involving any cervical spine (neck) or extremities (arms or legs), on the condition that lead shielding be used over the trunk of my body. I have been advised that certain x-rays, particularly those involving the pelvis, can be hazardous to a fetus.
Initial ___

Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.
Initial ___

Financial Obligation

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.

You may direct any questions regarding this financial obligation to the clinic manager or physician.
Initial ___

Signature Date

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Patient: ______________________________

Patient Profile

Personal Information

Full Name: ______________________________ Jr / Sr
Last *First* *M.I.*

Address: ______________________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Primary Phone: ______________ H / M / B Alternate Phone: ______________ H / M / B

Birth Date: ____ / ____ / ____

Social Security Number #: ____ - ____ - ____

Gender: ☐ Male ☐ Female

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined ☐ Unknown/Unavailable
☐ Other ______________________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined ☐ Unknown/Unavailable

Prim. Language: ☐ Arabic ☐ Chinese ☐ English ☐ French ☐ German ☐ Greek ☐ Hebrew ☐ Italian
☐ Japanese ☐ Korean ☐ Spanish ☐ Vietnamese ☐ Declined ☐ Unknown/Unavailable
☐ Other ______________________________

Email Address: ______________________________

Emergency Contact: ______________ Emergency Contact Phone: ______________

Time Zone: ______________________________

Does your time zone participate in Daylight Savings Time? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Do you have any dependents? ☐ Yes ☐ No

Are you a full-time student? ☐ Yes ☐ No

Health Insurance? ☐ Yes ☐ No

Responsible Party: ☐ You ☐ Other (parent, spouse, etc.) ______________________________

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Physician Form

Physician Information

Type of Physician: ☐ Chiropractic ☐ Family ☐ Specialist

Physician Name: ______________________
First Name *Last Name*

Address: ______________________
Street Address *Unit #*

____
City *State* *ZIP Code*

Phone: ______________ Ext. ______ Fax: ______________

Email Address: ______________________

Type of Physician: ☐ Chiropractic ☐ Family ☐ Specialist

Physician Name: ______________________
First Name *Last Name*

Address: ______________________
Street Address *Unit #*

____
City *State* *ZIP Code*

Phone: ______________ Ext. ______ Fax: ______________

Email Address: ______________________

Type of Physician: ☐ Chiropractic ☐ Family ☐ Specialist

Physician Name: ______________________
First Name *Last Name*

Address: ______________________
Street Address *Unit #*

____
City *State* *ZIP Code*

Phone: ______________ Ext. ______ Fax: ______________

Email Address: ______________________

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Employer Form

Employer Information

Your Employment Status: ☐ Full Time ☐ Part Time ☐ Contract ☐ Not Employed ☐ Retired ☐ Student

Occupation or Title: ______________________

Employer Name: ______________________

Employer Address: ______________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Employer Phone: ______________________ Ext. ______ Fax: ______________________

Start Date: ___/___/______ End Date: (If you are no longer working here.) ___/___/______

Your Employment Status: ☐ Full Time ☐ Part Time ☐ Contract ☐ Not Employed ☐ Retired ☐ Student

Occupation or Title: ______________________

Employer Name: ______________________

Employer Address: ______________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Employer Phone: ______________________ Ext. ______ Fax: ______________________

Start Date: ___/___/______ End Date: (If you are no longer working here.) ___/___/______

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Responsible Party Form

Responsible Party Information

Relationship to You: ______________________

Full Name: ______________________
First *M.I.* *Last*

Same as your address? ☐ Yes ☐ No

Address: ______________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

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Patient: ______________________________

Health Insurance Information

Are you the insured party? ☐ Yes ☐ No (if no please fill out the Policy Holder Information)

Policy Holder Information

Full Name: ______________________________
Last *First* *M.I.*

Relationship to you: ______________________________

Address: ______________________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Birth Date: ____ / ____ / ____

Social Security Number #: ____ - ____ - ____

Insured's Occupation: ______________________________

Insured's Employer: ______________________________

Employer Address: ______________________________
Street Address *Unit #*

____
City *State* *ZIP Code*

Employer Phone: ______________________________ Ext. ______

Insurance Company Information

Insurance Company Name: ______________________________

Address: ______________________________
Street Address *Unit #*

____
City *State* *ZIP Code*

Phone: ______________________________ Ext. ______ Fax: ______________________________

Group #: ______________________________

Policy/Subscriber #: ______________________________

Effective Date: ____ / ____ / ____ Expiration Date: ____ / ____ / ____

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Patient: ______________________________

Health History Form

Prescription Medications

Prescription medications taken on a regular or ongoing basis:

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

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Over-The-Counter Medications

Over-the-counter medications taken on a regular or ongoing basis:

Medication: ____________ Dosage: ______ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ______ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ______ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ______ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ______ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ______ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ______ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ______ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ______ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ______ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ______ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ______ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

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Vitamins, Minerals, Herbs, or Dietary Supplements

Vitamins, minerals, herbs, or dietary supplements taken on a regular or ongoing basis:

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

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Diet and Exercise

Check if you have ever smoked cigars or cigarettes. ☐ Yes

Check if you still smoke. ☐ Yes

How much do you smoke? ☐ Less than one pack per week ☐ 1-2 packs per week

☐ 1 pack every two days ☐ 1 pack per day ☐ More than one pack per day

Check if you drink alcoholic beverages. ☐ Yes

How many alcoholic beverages do you consume per week? _________

Check if a physician has ever diagnosed you as an alcoholic. ☐ Yes

Check if a physician has ever diagnosed you with any liver-related problems. ☐ Yes

Check if you exercise regularly. ☐ Yes

How many days do you exercise each week? _________

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Allergies

Check if a physician has ever diagnosed you with any allergies. ☐ Yes

Do you have Airborne allergies? ☐ Yes

☐ Animal ☐ Molds/Fungus ☐ Pollens ☐ Other ____________

☐ Cat Hair ☐ Cockroach ☐ Dog Hair ☐ Feather Mix

☐ Guinea Pig Hair ☐ Dust Mites ☐ Other ____________

Do you have Chemical allergies? ☐ Yes

☐ Acetone ☐ Acetylcholine ☐ Auto Exhaust ☐ Benzyl Alcohol ☐ Chlorine

☐ Citric Acid ☐ Cologne (all) ☐ Diesel Exhaust ☐ Dopamine ☐ Estradiol

☐ Ethanol ☐ Fluorine ☐ Formaldehyde ☐ Latex ☐ Melatonin

☐ Newspaper Print ☐ Norepinephrine ☐ Progesterone ☐ Propylene ☐ Serotonin

☐ Silicone Implant ☐ Sponge Rubber ☐ Toluene ☐ Trichloroethylene ☐ Wood Pulp

☐ Xylene ☐ Other ____________

Do you have Drug allergies? ☐ Yes

☐ Anticonvulsants ☐ Codeine ☐ Insulin Preparations ☐ Iodine ☐ Morphine

☐ Novocain ☐ Penicillin ☐ Sulfa ☐ Other ____________

Do you have Food allergies? ☐ Yes

☐ Artificial Colorings ☐ Artificial Flavorings ☐ Beef ☐ Coffee/Tea ☐ Dairy

☐ Eggs ☐ Fish/Shellfish ☐ Fruits ☐ Lamb ☐ Nuts

☐ Pork ☐ Poultry ☐ Vegetables ☐ Other ____________

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Surgical History

Check if you have any implants, screws, plates or other foreign objects in your body. ☐ Yes

☐ Bullet Wound(s) ☐ Infusion Catheter ☐ Ear Implant ☐ Pacemakers ☐ Eye Implant

☐ Brain Plate(s) ☐ Heart Valve(s) ☐ Shrapnel ☐ Other ____________

Musculoskeletal Surgeries (Check if you have had any of the following surgeries)

☐ Ankle	Year(s) of surgery: ________	☐ Head	Year(s) of surgery:	________
☐ Back	Year(s) of surgery: ________	☐ Hip	Year(s) of surgery:	________
☐ Cosmetic or Augmentation	Year(s) of surgery: ________	☐ Knee	Year(s) of surgery:	________
☐ Elbow	Year(s) of surgery: ________	☐ Neck	Year(s) of surgery:	________
☐ Foot	Year(s) of surgery: ________	☐ Shoulder	Year(s) of surgery:	________
☐ Hand	Year(s) of surgery: ________	☐ Wrist	Year(s) of surgery:	________
☐ Other	Please describe: ________		Year(s) of surgery:	________

Organ System Surgeries (Check if you have had any of the following surgeries)

☐ Brain	Year(s) of surgery: ________	☐ Intestine, large	Year(s) of surgery:	________
☐ Colon	Year(s) of surgery: ________	☐ Liver	Year(s) of surgery:	________
☐ Esophagus	Year(s) of surgery: ________	☐ Lung	Year(s) of surgery:	________
☐ Eye	Year(s) of surgery: ________	☐ Mastectomy	Year(s) of surgery:	________
☐ Heart	Year(s) of surgery: ________	☐ Reproductive Organs	Year(s) of surgery:	________
☐ Kidney	Year(s) of surgery: ________	☐ Skin	Year(s) of surgery:	________
☐ Intestine, small	Year(s) of surgery: ________	☐ Throat	Year(s) of surgery:	________
☐ Other	Please describe: ________		Year(s) of surgery:	________
☐ Transplant	Please describe: ________		Year(s) of surgery:	________

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Your Cancer History

Check if a physician has ever diagnosed you with cancer. ☐ Yes

Check all that apply

- ☐ Bladder
- ☐ Brain
- ☐ Breast
- ☐ Cervical
- ☐ Colon or Rectal
- ☐ Endometrial
- ☐ Eye
- ☐ Kidney (renal cell)
- ☐ Leukemia
- ☐ Other ____________________
- ☐ Lung
- ☐ Non-Hodgkin's Lymphoma
- ☐ Ovarian
- ☐ Pancreatic
- ☐ Prostate
- ☐ Skin
    - ☐ Basal Cell Carcinoma
    - ☐ Squamous Cell Carcinoma
    - ☐ Melanoma
- ☐ Stomach
- ☐ Thyroid
- ☐ Uterine

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Family Cancer History

Check if a physician has ever diagnosed your family with cancer. ☐ Yes

Check all that apply and the family member(s) who had this condition:

- ☐ *Bladder (M, F, S, MG, PG)*
- ☐ *Brain (M, F, S, MG, PG)*
- ☐ *Breast (M, F, S, MG, PG)*
- ☐ *Cervical (M, F, S, MG, PG)*
- ☐ *Colon or Rectal (M, F, S, MG, PG)*
- ☐ *Endometrial (M, F, S, MG, PG)*
- ☐ *Eye (M, F, S, MG, PG)*
- ☐ *Kidney (renal cell) (M, F, S, MG, PG)*
- ☐ *Leukemia (M, F, S, MG, PG)*
- ☐ Other ____________________ *(M, F, S, MG, PG)*
- ☐ *Lung (M, F, S, MG, PG)*
- ☐ *Non-Hodgkin's Lymphoma (M, F, S, MG, PG)*
- ☐ *Ovarian (M, F, S, MG, PG)*
- ☐ *Pancreatic (M, F, S, MG, PG)*
- ☐ *Prostate (M, F, S, MG, PG)*
- ☐ *Skin (M, F, S, MG, PG)*
  - ☐ *Basal Cell Carcinoma (M, F, S, MG, PG)*
  - ☐ *Squamous Cell Carcinoma (M, F, S, MG, PG)*
  - ☐ *Melanoma (M, F, S, MG, PG)*
- ☐ Stomach *(M, F, S, MG, PG)*
- ☐ Thyroid *(M, F, S, MG, PG)*
- ☐ Uterine *(M, F, S, MG, PG)*

Family Members	
(M)	Mother
(F)	Father
(S)	Sibling
(MG)	Maternal Grandparent
(PG)	Paternal Grandparent

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Your Cardio-pulmonary / Circulatory Health

Check if a physician has ever diagnosed you with any of the following:

- ☐ Anemia
- ☐ HIV/AIDS
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hypertension (high blood pressure)
- ☐ Hypotension (low blood pressure)
- ☐ Hemorrhoids
- ☐ Lung Disorders
  - ☐ Acute Respiratory Distress Syndrome
  - ☐ Alpha-1 Antitrypsin Deficiency
  - ☐ Asbestos/Dust Disease
  - ☐ Asthma
  - ☐ Bronchiectasis
  - ☐ Bronchitis (chronic)
  - ☐ Bronchopulmonary Dysplasia (BPD)
  - ☐ Chronic Obstructive Pulmonary Disease
  - ☐ Cystic Fibrosis
  - ☐ Emphysema
  - ☐ Farmer's Lung
  - ☐ Hantavirus
  - ☐ Histoplasmosis
  - ☐ Legionellosis
  - ☐ Lymphangioleiomyomatosis
  - ☐ Pleurisy
  - ☐ Pneumonia
  - ☐ Pneumothorax
  - ☐ Primary Alveolar Hypoventilation Syndrome
  - ☐ Pulmonary Alveolar Proteinosis
  - ☐ Pulmonary Embolus
  - ☐ Pulmonary Fibrosis
  - ☐ Respiratory Distress Syndrome
  - ☐ Respiratory Syncytial Virus
  - ☐ Sarcoidosis
  - ☐ Severe Acute Respiratory Syndrome
  - ☐ Spontaneous Pneumothorax
  - ☐ Tuberculosis
- ☐ Raynaud's Phenomenon
- ☐ Sickle Cell Anemia
- ☐ Sinus Infections (chronic)
- ☐ Stroke
- ☐ Wegener's Granulomatosis
- ☐ Other ____________________

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Family Cardio-pulmonary / Circulatory Health

Check if a physician has ever diagnosed your family with any of the following:

- ☐ Anemia *(M, F, S, MG, PG)*
- ☐ HIV/AIDS *(M, F, S, MG, PG)*
- ☐ Hemophilia *(M, F, S, MG, PG)*
- ☐ Hepatitis *(M, F, S, MG, PG)*
- ☐ Hypertension (high blood pressure) *(M, F, S, MG, PG)*
- ☐ Hypotension (low blood pressure) *(M, F, S, MG, PG)*
- ☐ Hemorrhoids *(M, F, S, MG, PG)*
- ☐ Lung Disorders *(M, F, S, MG, PG)*
  - ☐ Acute Respiratory Distress Syndrome *(M, F, S, MG, PG)*
  - ☐ Alpha-1 Antitrypsin Deficiency *(M, F, S, MG, PG)*
  - ☐ Asbestos/Dust Disease *(M, F, S, MG, PG)*
  - ☐ Asthma *(M, F, S, MG, PG)*
  - ☐ Bronchiectasis *(M, F, S, MG, PG)*
  - ☐ Bronchitis (chronic) *(M, F, S, MG, PG)*
  - ☐ Bronchopulmonary Dysplasia(BPD) *(M, F, S, MG, PG)*
  - ☐ Chronic Obstructive Pulmonary Disease *(M, F, S, MG, PG)*
  - ☐ Cystic Fibrosis *(M, F, S, MG, PG)*
  - ☐ Emphysema *(M, F, S, MG, PG)*
  - ☐ Farmer's Lung *(M, F, S, MG, PG)*
  - ☐ Hantavirus *(M, F, S, MG, PG)*
  - ☐ Histoplasmosis *(M, F, S, MG, PG)*
  - ☐ Legionellosis *(M, F, S, MG, PG)*
  - ☐ Lymphangioleiomyomatosis *(M, F, S, MG, PG)*
  - ☐ Pleurisy *(M, F, S, MG, PG)*
  - ☐ Pneumonia *(M, F, S, MG, PG)*
  - ☐ Pneumothorax *(M, F, S, MG, PG)*
  - ☐ Primary Alveolar Hypoventilation Syndrome *(M, F, S, MG, PG)*
  - ☐ Pulmonary Alveolar Proteinosis *(M, F, S, MG, PG)*
  - ☐ Pulmonary Embolus *(M, F, S, MG, PG)*
  - ☐ Pulmonary Fibrosis *(M, F, S, MG, PG)*
  - ☐ Respiratory Distress Syndrome *(M, F, S, MG, PG)*
  - ☐ Respiratory Syncytial Virus *(M, F, S, MG, PG)*
  - ☐ Sarcoidosis *(M, F, S, MG, PG)*
  - ☐ Severe Acute Respiratory Syndrome *(M, F, S, MG, PG)*
  - ☐ Spontaneous Pneumothorax *(M, F, S, MG, PG)*
  - *(M, F, S, MG, PG)*
  - ☐ Tuberculosis *(M, F, S, MG, PG)*
- ☐ Raynaud's Phenomenon *(M, F, S, MG, PG)*
- ☐ Sickle Cell Anemia *(M, F, S, MG, PG)*
- ☐ Sinus Infections (chronic) *(M, F, S, MG, PG)*
- ☐ Stroke *(M, F, S, MG, PG)*
- ☐ Wegener's Granulomatosis *(M, F, S, MG, PG)*
- ☐ Other ____________________ *(M, F, S, MG, PG)*

Family Members	
(M)	Mother
(F)	Father
(S)	Sibling
(MG)	Maternal Grandparent
(PG)	Paternal Grandparent

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Endocrine, Gastrointestinal and Neurologic Health

Check if a physician has ever diagnosed you with any of the following:

- ☐ Autoimmune Disorder
  - ☐ Dermatitis
  - ☐ Churg-Strauss (Allergic Granulomatosis)
  - ☐ Eosinophilic Fasciitis
  - ☐ Dermatomyositis/Polymyositis
  - ☐ Goodpasture's Syndrome
  - ☐ Interstitial Granulomatous Dermatitis with Arthritis
  - ☐ Lupus
    - ☐ Lupus SLE
    - ☐ Lupus DLE
    - ☐ Lupus SCLE
    - ☐ Anti-Phospholipid Antibody Syndrome (Lupus Anticoagulant)
  - ☐ Mixed Connective Tissue Disease
  - ☐ Relapsing Polychondritis
  - ☐ Rheumatoid Arthritis
  - ☐ Sarcoidosis
  - ☐ Scleroderma
  - ☐ Sjogren's Syndrome
  - ☐ Skin Immunofluorescence
  - ☐ Vasculitis
- ☐ Bladder Disease
- ☐ Candida
- ☐ Chicken Pox
- ☐ Chronic Fatigue Syndrome
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gall Bladder Problems
- ☐ Headaches
  - ☐ Cluster Headaches
  - ☐ Migraine Headaches
  - ☐ Sinus Headaches
  - ☐ Stress-induced Headaches
  - ☐ Tension Headaches
- ☐ Incontinence
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Liver Problems
- ☐ Measles
- ☐ Mumps
- ☐ Seizures
- ☐ Shingles
- ☐ Stomach Ulcers
- ☐ Thyroid Dysfunction
- ☐ Urinary Tract Infection
- ☐ Other ____________________________

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Emotional and Mental Health

Check if a physician has ever diagnosed you with an emotional or mental condition. ☐ Yes

☐ Anger Disorders
☐ Anxiety Disorders
☐ Asperger Syndrome
☐ Attention Deficit Disorder with Hyperactivity (ADHD)
☐ Autistic Disorder
☐ Avoidant Personality Disorder (AvPD)
☐ Bipolar Disorder
☐ Borderline Personality Disorder
☐ Capgras Syndrome
☐ Child Behavior Disorders
☐ Combat Disorders
☐ Cyclothymic Disorder
☐ Dependent Personality Disorder (DPD)
☐ Depressive Disorders (depression)
☐ Dissociative Disorders
☐ Dysthymic Disorders (mood disorder)
☐ Eating Disorders
☐ Firesetting Behavior
☐ Hypochondriasis (Somatoform Disorder)
☐ Impulse Control Disorders
☐ Kleine-Levin Syndrome
☐ Kleptomania
☐ Multiple Personality Disorder
☐ Munchhausen Syndrome
☐ Narcissistic Personality Disorder
☐ Narcolepsy
☐ Obsessive Compulsive Disorder (OCD)
☐ Phobic Disorders (Phobias)
☐ Psychotic Disorders
☐ Restless Legs Syndrome
☐ Schizophrenia
☐ Seasonal Affective Disorder
☐ Sexual or Gender Disorders
☐ Sexual Dysfunctions (psychological, not physical)
☐ Sleep Disorders
☐ Post-traumatic Stress Syndrome
☐ Substance Abuse
☐ Suicidal Tendencies
☐ Other ____________________________

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Sensory Health

Check if a physician has ever diagnosed you with any of the following:

- ☐ Blindness
- ☐ Cataract
- ☐ Cholesteatoma
- ☐ Deafness or Hearing Loss
- ☐ Ear ringing
- ☐ Eczema
- ☐ Glaucoma
- ☐ Laryngitis (chronic)
- ☐ Macular Degeneration
- ☐ Mumps
- ☐ Meniere's Disease
- ☐ Nasal Polyps
- ☐ Perforated Eardrum
- ☐ Psoriasis
- ☐ Rhinitis
- ☐ Sinusitis
- ☐ Tinnitus
- ☐ Unusual Vision Impairment
- ☐ Vertigo
- ☐ Other ____________________

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Musculoskeletal Health

Check if a physician has ever diagnosed you with any of the following:

- ☐ Arthritis
  - ☐ Ankylosing Spondylitis
  - ☐ Behets Disease
  - ☐ Carpal Tunnel Syndrome
  - ☐ Diffuse Idiopathic Skeletal Hyperostosis (DISH)
  - ☐ Ehlers-Danlos Syndrome (EDS)
  - ☐ Felty's Syndrome
  - ☐ Fibromyalgia
  - ☐ Infectious Arthritis
  - ☐ Mixed Connective Tissue Disease (MCTD)
  - ☐ Osteoarthritis
  - ☐ Osteoporosis
  - ☐ Paget's Disease
  - ☐ Polymyalgia Rheumatica
  - ☐ Polymyositis and Dermatomyositis
  - ☐ Pseudogout
  - ☐ Psoriatic Arthritis
  - ☐ Reactive Arthritis
  - ☐ Repetitive Stress Injury
  - ☐ Rheumatoid Arthritis
  - ☐ Scleroderma
  - ☐ Sjogren's Syndrome
  - ☐ Stills Disease
- ☐ Gout
- ☐ Herniated Disk
- ☐ Lyme Disease
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Numbness or Tingling in feet
- ☐ Numbness or Tingling in hands
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Polio
- ☐ Rheumatism
- ☐ Sciatica
- ☐ Temporomandibular Joint Syndrome (TMJ)
- ☐ Other ______________________

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Reproductive Health

Check if you have ever given birth. ☐ Yes

How many births vaginally? ___________

How many births by C-section? ___________

Check if a physician has ever diagnosed you with any of the following:

☐ Chlamydia ☐ Dysplasia ☐ Erectile Dysfunction ☐ Genital Herpes

☐ Gonorrhea ☐ Human Papillomavirus (HPV) ☐ Impotency ☐ Syphilis

☐ Infertility ☐ Cystitis ☐ Menopause ☐ Prostate Enlargement

☐ Testicular Dysfunction ☐ Uterine Fibroid ☐ Vaginal Yeast Infections (chronic) ☐ Other ________________________

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Patient: ________________________________

Chief Complaint Form

Chief Complaint

Case Title: ________________________________

Describe the reason for your visit: ________________________________

____

____

When did your symptoms begin? (select one)

☐ Today ☐ This week ☐ Within last 3 months

☐ 3 months to 6 months ☐ 6 months to one year ☐ More than one year

For Women Only: Most recent menstrual cycle: ____/____/____

Are you pregnant? ☐ Yes ☐ No

Which word describes the frequency of your discomfort? (select one)

☐ Constant ☐ Intermittent ☐ Occasional ☐ Rare

Which phrases best describe *changes* in your discomfort during the day? (select one or more)

☐ It is worse in the morning ☐ It is worse in the afternoon ☐ It is worse at night

☐ It changes with the weather ☐ It does not change

What helps *relieve* your discomfort? (select one or more)

☐ Ice ☐ Heat ☐ Medication ☐ Other (please describe) ________________

What activities are limited by your discomfort? (select one or more)

☐ Bending ☐ Bowel Movements ☐ Coughing ☐ Daily Routine

☐ Driving ☐ Getting Up ☐ Lifting ☐ Lying Down

☐ Pulling ☐ Pushing ☐ Reading ☐ Sitting

☐ Sleeping ☐ Sneezing ☐ Standing ☐ Turning my head

☐ Urination ☐ Walking ☐ Working ☐ Other (please describe) ________________

Where applicable, specify the approximate date of your most recent: (month / year)

Physical Exam: ____/____ Dental X-rays: ____/____

Spinal X-ray: ____/____ CT Scan: ____/____

MRI: ____/____ Other Scans or X-rays: ____/____

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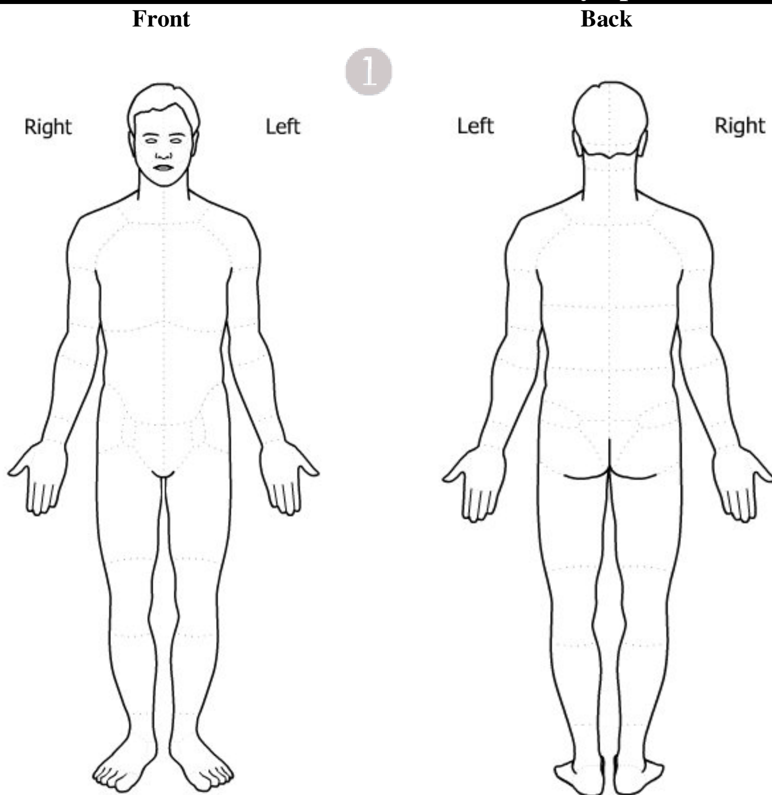
Patient: ______________________________

Patient Symptom Illustrator

Patient Symptom Illustrator



Instructions:

1 Identify your areas of discomfort by marking the affected body parts in the illustration.

2 Indicate the area name along with your specific symptoms associated with each selected area.

3 Rate your discomfort associated with each selected area.

2

3

0 = No Discomfort 10 = Severe Discomfort

	Area	Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Swelling	Stiffness	Rating
Ex.	L (R) Lower Back			X			X			X	0 1 2 3 4 5 6 X 8 9 10
1.	L R										0 1 2 3 4 5 6 7 8 9 10
2.	L R										0 1 2 3 4 5 6 7 8 9 10
3.	L R										0 1 2 3 4 5 6 7 8 9 10
4.	L R										0 1 2 3 4 5 6 7 8 9 10

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