# DIAMOND STATE CHIROPRACTIC, P.A.

*Kristina A. Hollstein, D.C., D.A.B.C.O & Gregory J. Serge, D.C., F.I.A.M.A*

**Today's Date:** ___________________ **Who is your Primary Doctor?** ___________________________

**Patient Title:** (check one) ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Miss ◯ Dr ◯ Prof ◯ Rev

**First Name:** ___________________________ **Nick Name:** _____________________________________

**Last Name:** _____________________________ **Middle Int:** _________ **Suffix:** _____________________

**Address:** _____________________________________________________________________________

**City:** _________________________________ **State:** _____________ **Zip Code:** ____________________

**Social Security number:** ____________________ **Marital Status:** ◯ Single ◯ Married ◯ Other

**Date of Birth:** _________________________ **Gender:** ◯ Male ◯ Female ◯ Unspecified

**Primary Phone Number:** __________________________ (Home, work, cell) ______________________

**Would you like to have text/email reminders about your future appointments:** ◯ Yes ◯ No

**Secondary Phone Number:** _________________________ (Home, work, cell) _____________________

**Email address:** ________________________________________________________________________

**Employment Status:** ◯ Employed: Who is your employer: ___________________________________

◯ Full Time Student ◯ Student ◯ Retired ◯ Self Employed

**Do you currently or have use tobacco of any kind?** ◯ No ◯ Yes (How much per day? __________

◯ Former smoker ◯ Never smoked

## Review of Systems

(Please check all that applies)

**Cardiovascular issues?** No to all ◯

◯ Aortic Aneurism ◯ Chest Pain ◯ Heart Attack ◯ Heart Disease ◯ High Blood Pressure

◯ High Cholesterol ◯ Vascular Disease ◯ Pace Maker ◯ Blood Clots ◯ Swelling of Legs

**Genitourinary issues?** No to all ◯

◯ Blood in Urine ◯ Painful Urination ◯ Frequent Urination ◯ Kidney DiseaseKidney Stones

**Hematologic/lymphatic problems?** No to all ◯

◯ Blood clots ◯ Hepatitis ◯ Easy Bleeding ◯ Easy Bruising ◯ Fever/Chills/Sweats

**Neurological issues?** No to all ◯

◯ Carpal Tunnel ◯ Brain/Head Injury ◯ Numbness ◯ Parkinson's Disease

◯ Seizures ◯ Severe Headaches ◯ Dizziness/Balance ◯ Stroke

**Respiratory issues?** No to all ◯

◯ Asthma ◯ Sleep Apnea ◯ Emphysema ◯ Shortness of Breath ◯ Pneumonia

◯ Tuberculosis

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**Head and ENT issues?** No to all ◯

◯ Bleeding Gums ◯ Difficulty Swallowing ◯ Dizziness ◯ Hearing

◯ Nose Bleed ◯ Sinus Infection

**Eye conditions?** No to all ◯

◯ Blurred Vision ◯ Double Vision ◯ Glaucoma ◯ Cataracts

**Dermatological issues?** No to all ◯

◯ Eczema ◯ Psoriasis ◯ Rashes ◯ Skin Disease ◯ Skin Ulcers

**Psychiatric complaints?** No to all ◯

◯ Anxiety Disorder ◯ Depression

**Endocrine issues?** No to all ◯

◯ Diabetes ◯ Hair Loss ◯ Menopausal ◯ Thyroid Disease

**Weight changes, weakness, fatigue, or fever?** No to all ◯

◯ Fatigue/Weakness ◯ Weight Loss ◯ Weight Gain

**Gastrointestinal issues?** No to all ◯

◯ Bloody Stools ◯ Bowel Problems ◯ Constipation ◯ Gallbladder ◯ Liver Disease

◯ Nausea/Vomiting ◯ Poor Appetite ◯ Ulcers

**Musculoskeletal issues?** No to all ◯

◯ Arthritis ◯ Broken Bones ◯ Gout ◯ Joints Replaced

◯ Joint Stiffness/Pain ◯ Muscle Weakness ◯ Osteoporosis

**Do you have any personal history of Cancer?** No to all ◯

◯ Breast ◯ Lung ◯ Prostate ◯ Thyroid ◯ Skin ◯ Other: ____________________________

**Patient's surgical history?** No to all ◯

◯ Discectomy ◯ Spinal Fusion ◯ Gallbladder Removed ◯ Hysterectomy

◯ Gastric Bypass ◯ Other: ____________________________________________________________

**Current medication(s)?** If there are no current medications check here: ◯
(Dose and Frequency) ________________________________ ________________________________

________________________________ ________________________ __________________________

________________________________ ________________________ __________________________

**Do you have any drug allergy?** If no allergies, check here: ◯

________________________________ ________________________ __________________________

________________________________ ________________________ __________________________

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## Immediate Family Health History:

**M**=Mother **F**=Father **B**=Brother **SO**=Son **S**=Sister **DA**=Daughter

**Cancer**: ____________ **Type**: ___________ **Hypertension**: _____________________________
**Dementia/Alz:** _____ **Type**: ___________ **Kidney Disease**: ___________ **Type**: ___________
**Diabetes:** __________ **Type**: ___________ **Lung Disease**: ____________ **Type**: ___________
**Heart Disease:** ______**Type**: ___________ **Osteoporosis**: ____________ **Type**: ___________
**High Cholesterol**: _____________________ **Stroke/Brain**: _____________ **Type**: ____________

**Social habits**? ◯ Does not smoke, drink alcohol, or take rec. drugs.
◯ Is a social drinker ◯ Current every day smoker ◯ Former Smoker ◯ Never Smoked

**Have you received any past care for this complaint?** ◯ No ◯ Yes
If yes where and when: ____________________________________________________________

**Patient height?**_ _________ **Patients Weight?** __________?

## Describe your current problem?

**When did your symptoms begin?** (Must be within the past 30 days for Acute) ____/____/_____

**What caused your symptoms?** (Ex: Lawn/gardening, Lifting, Slept wrong) _________________________

**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)

1. **Chief Complaint – Where is your pain located?**
   ◯ Neck Pain ◯ Upper Back Pain ◯ Mid Back Pain ◯ Low Back Pain
   ◯ Other areas not listed? ______________________________________________________

What is your pain level on the worst day with 0 being no pain and 10 being unbearable? ______________

**Describe your symptoms and type of pain: (Check all that applies)** ◯ Dull ◯ Sharp ◯ Throbbing

◯ Burning ◯ Stiffness ◯ Aching ◯ Tingling ◯ Stabbing ◯ Cramping

◯ Numbness ◯ Radiating – Where does it radiate to? ________________________________

**What aggravates your symptoms? (Check all that applies)** ◯ Sitting ◯ Standing ◯ Walking

◯ Bending ◯ Stooping ◯ Lifting ◯ Sleeping ◯ Sneezing ◯ Coughing ◯ Driving

◯ Reaching ◯ Twisting ◯ Looking up ◯ Looking down ◯ Movement ◯ Rest ◯ Laying down

**What *relieves* your symptoms? (Check all that applies)** ◯ Sitting ◯ Standing ◯ Lying

◯ Knees bent up ◯ Support ◯ No movement ◯ Movement ◯ Heat ◯ Ice ◯ Analgesics
◯ Topical ◯ Ibuprofen ◯ Medication ◯ Rest ◯ Stretching/exercise ◯ Adjustments

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**2. <u>Chief Complaint</u> – Where is your pain located?**
◯ Neck Pain ◯ Upper Back Pain ◯ Mid Back Pain ◯ Low Back Pain

What is your pain level on the worst day with 0 being no pain and 10 being unbearable? ____________

**Describe your symptoms and type of pain: (Check all that applies)** ◯ Dull ◯ Sharp ◯ Throbbing

◯ Burning ◯ Stiffness ◯ Aching ◯ Tingling ◯ Stabbing ◯ Cramping

◯ Numbness ◯ Radiating – Where does it radiate to? __________________________________

**What <u>aggravates</u> your symptoms? (Check all that applies)** ◯ Sitting ◯ Standing ◯ Walking

◯ Bending ◯ Stooping ◯ Lifting ◯ Sleeping ◯ Sneezing ◯ Coughing ◯ Driving

◯ Reaching ◯ Twisting ◯ Looking up ◯ Looking down ◯ Movement ◯ Lying

**What <u>relieves</u> your symptoms? (Check all that applies)** ◯ Sitting ◯ Standing ◯ Lying

◯ Knees bent up ◯ Support ◯ No movement ◯ Movement ◯ Heat ◯ Ice ◯ Analgesics
◯ Topical ◯ Ibuprofen ◯ Medication ◯ Rest ◯ Stretching/exercise ◯ Adjustments

**3. <u>Chief Complaint</u> – Where is your pain located?**
◯ Neck Pain ◯ Upper Back Pain ◯ Mid Back Pain ◯ Low Back Pain

What is your pain level on the worst day with 0 being no pain and 10 being unbearable? ____________

**What <u>aggravates</u> your symptoms? (Check all that applies)** ◯ Sitting ◯ Standing ◯ Walking

◯ Bending ◯ Stooping ◯ Lifting ◯ Sleeping ◯ Sneezing ◯ Coughing ◯ Driving

◯ Reaching ◯ Twisting ◯ Looking up ◯ Looking down ◯ Movement ◯ Lying

**What *relieves* your symptoms? (Check all that applies)** ◯ Sitting ◯ Standing ◯ Lying

◯ Knees bent up ◯ Support ◯ No movement ◯ Movement ◯ Heat ◯ Ice
◯ Analgesics ◯ Topical ◯ Ibuprofen ◯ Medication ◯ Rest ◯ Stretching/exercise

**Who have you seen for your symptoms?** ◯ No one ◯ Medical Doctor ◯ P.T.

1101 Twin C Lane, Suite 201, Newark, DE 19713
Telephone 302.892.9355 Facsimile 302.892.3494
**Please either fax us these forms back or email them to dsc103@comcast.net**

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_______________________________________________ _____________________________
Print Name: Date of Birth

________________________________________________________________________________
Street Address: City: Zip Code

## *Acknowledgement of Receipt of September 23, 2013 Notice of Privacy Practices.* (A copy of the privacy practice can be obtained at the front desk, if you prefer to sign upon arrival.)

By signing this document, I acknowledge that I have reviewed a copy of the Notice of Privacy Practices of Diamond State Chiropractic, P.A.

**Signature**: _______________________________________ **Date**: _______________________

## *Missed Appointment Fee*

We require 24-hour advance notice if you are unable to make your appointment. Otherwise, you will be charged a nominal fee of $5.00 to $10.00.

**Signature**: _______________________________________ **Date**: _______________________

## *Informed Consent for Chiropractic Treatment*

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about it content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**Signature**: _______________________________________ **Date**: _______________________

## *Authorization for Release of Medical Records and Signature on File*

By signing this, I authorize Diamond State Chiropractic to obtain all medical information regarding my condition when under any treatment to include: history, findings, x-rays, any diagnostic test, and diagnosis, as well as subsequent or future developments.

I authorize the use of this form on all my insurance submissions. I authorize release of information to all of my insurance companies. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize payment directly to my doctor.

**Signature**: _______________________________________ **Date**: _______________________

**Staff Signature:** ___________________________________ **Date:** _______________________

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