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:_____ **Your General Health Insurance Carrier:** _____

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

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

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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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: _____

Surgical history? No to all ◯

◯ Discectomy ◯ Spinal Fusion ◯ Gallbladder Removed ◯ Hysterectomy

◯ Gastric Bypass ◯ Other: _____

Medication(s)? If not on any medication please check none: ◯ None

(Dose and Frequency) _____

_____ _____ _____

_____ _____ _____

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

_____ _____ _____

_____ _____ _____

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

Patient height?_____ **Patients Weight?** _____?

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Describe your current problem?

When did your symptoms worsen? (Must be within past 30 days for insurance) ____/____/_____

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)

Main Complaint – Where is your pain located?

◯ Neck Pain ◯ Upper Back Pain ◯ Mid Back Pain ◯ Low Back Pain

◯ Does pain radiate? If so, where to: _____

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

2nd Problem area: _____ Pain # _____ (Remember on your worst day)

3rd Problem area: _____ Pain # _____ (Remember on your worst day)

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

Who have you seen for your symptoms? _____

What treatment did you receive? _____

What test have you had for your symptoms? ◯ None ◯ MRI ◯ X-Ray ◯ Ct scan ◯ Other: _____

How long ago were these tests done? ◯ None ◯ Less than 2 years ◯ 2 to 5 years

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Reference our website for the actually documents

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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