AIIH/Bermuda Chiropractic Health Centre

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

_____

Email: _____

Sex: ☐ M ☐ F Age_____ Birth date:_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation _____

Employer_____

Employer Phone No. _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account?_____

Relationship to Patient _____

Insurance Co: _____

Group# _____ Cert:# _____

Subscriber's Name _____

Birth date: _____Relationship to Patient _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that (or my dependent) have insurance coverage with _____ and assign directly to Dr._____ all insurance benefits if any, otherwise payable to me for services rendered. I Understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. **I understand that there is a charge for all missed Appointments that are not cancelled within 24 hours notice.**

Credit/Debit Card:_____

SIGNATURE:_____

DATE:_____

3 PHONE NUMBERS

Home:_____Work: _____Cell:_____

Best time and place to reach you?_____

IN CASE OF EMERGENCY, CONTACT

Name _____Relationship_____

Home Phone _____Work Phone_____

4 ACCIDENT /TRAUMA

Is condition due to an accident? ☐ Yes ☐ No Date_____

Type of accident ☐Auto ☐ Work ☐ Home ☐ Sports ☐ Other

To Whom have you made a report of your accident?

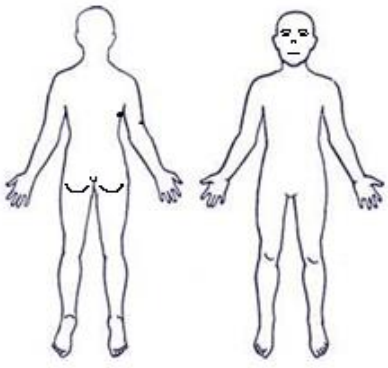
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other☐

Attorney Name (If applicable) _____

5 PATIENT CONDITION

Reason for Visit _____When did your symptoms appear? _____

Please Mark the location of problem.



Is the Condition: ☐ Getting Worse ☐ Improving ☐ Intermittent ☐ Comes & Goes ☐ Constant ☐ Unsure

Is the pain: ☐ Localized to a specific area, or ☐ Does it radiate

Is this condition getting progressively worse? ☐Yes ☐ No ☐ Unknown

What makes the problem better? _ _____ What makes the problem worse? _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐Cramps ☐Stiffness ☐ Swelling ☐ Other

Rate the severity of your pain of a scale from 1 (least pain) to 10 (Severe Pain) _____

Where is the problem located? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Intimacy ☐ Sports ☐ School

Activities/movements that are painful to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Chores ☐ Bathing ☐ Dressing ☐ Sleeping

6 REVIEW OF SYSTEMS

☐ **Dermatological**
Skin Disorders
Eczema/Rashes
Other:
_____

☐ **Cardiovascular**
Murmur
Flutter
Blood Pressure
Cholesterol
Other:
_____

☐ **Musculoskeletal**
Nerve Pain/sciatica Tingling
Fractures
Arthritis/Joint Pain
Disc. Degeneration
Sprain/Strain
Other:
_____

☐ **Gastrointestinal**
Reflux/GERD
Digestive Issues
Inflammatory Bowel Diseases
Other:
_____

☐ **Endocrine**
Adrenal Fatigue
Diabetes
Hormonal Conditions
Thyroid
Other:
_____

☐ **Respiratory**
Asthma/Allergies
Lung Conditions
Difficulty Breathing
Other:
_____

☐ **HEENT**
Head
Eyes/Vision Disturbance
Ears
Nose/Sinuses
Throat/Difficulty Swallowing
Other:
_____

☐ **Neurological**
Loss of Smell, Taste
Vision /Hearing
Tics, Seizures
Parkinson's
Pins/Needles/Numbness
Other:
_____

☐ **Genitourinary**
Urinary/Bladder
Kidney conditions
Infertility
Menstrual Cramps
Cyst/Endometriosis
Hemorrhoids
Prostate
Infections
Other:
_____

☐ **Psychiatric**
Stress
Depression
Mental Illness
ADD/ADHD/Autism
Speech Issues
Epilepsy
Focus Memory
Other:
_____

☐ **General/Immune**
Allergies
(Chronic Colds/Coughs
Immune Problems
Other:
_____

☐ **Hematological**
Blood Disorders
Anemia
Other:
_____

7 SOCIAL HABITS

EXERCISES
☐ Stretching ☐ Light
☐ Endurance ☐ Moderate
☐ Aerobics ☐ Heavy
☐ Wt. Training
☐ Sports
☐ None

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labour
☐ High Stress Level
☐ Heavy Lifting

SOCIAL ACTIVITY
☐ Smoking
☐ Alcohol
☐ Coffee/Caffeine Drinks
☐ High Stress
☐ Sleeps (☐ Stomach ☐ back)
☐ Water 8-10 Cups

DIET
☐ Dairy
☐ Gluten/Wheat
☐ Processed Foods
☐ Artificial Sweeteners
☐ Vegetarian/Vegan
☐ Ketogenic

Injuries/Surgeries you have Had? _____

Head Injuries:_____

Broken/Bones/Dislocations:_____

Prior Therapies/Chiropractic:_____

What are your goals for care?: ☐ Resolve existing conditions, ☐ Overall Wellness, ☐ Other health goals

List of Medications:_____ Vitamins/Supplements/Minerals:_____