Precision Chiropractic Center

857 North Main Street Ext.
Wallingford, CT 06492

Phone: (203) 284-9200
Fax: (203) 294-0410

Medicare Initial History

Patient Information:

PatientName: _____ Date: _____

Address:_____ Home Phone:_____

City:_____ State:____ Zip code:_____ Cell phone:_____

Sex: o Male oFemale Age:_____ Birthdate:_____ Work phone:_____

oMarried oWidowed oSingle oDivorced oPartnered for ___ years

Email: _____

Vitals: Ht: _____ Wt: _____BP: _____ Pulse: _____

Insurance:

Who is responsible for this account?_____ Relationship to Patient:_____

Insurance Company:_____ I.D #_____

Do you have additional insurance? oYes oNo

If yes, Name of insurance:_____ I.D.#_____

Patient Condition:

Chief Complaint (What is bothering you?):

_____

_____

_____

Mechanism of Trauma (How did it happen?):

_____

_____

Onset (When did it start?): _____

Quality/Character (sharp, dull, ache): _____

Frequency/Duration (When and how long?):

_____

_____

Better/Worse: _____

Referral/Other Symptoms: _____

Previous Occurrences: _____

Secondary Complaints: _____

Previous Care: _____

Relative Contraindications:

Do you have any of the following conditions?

❑Joint Hypermobility ❑Osteoporosis/Osteopenia ❑Benign Bone Tumors ❑Bleeding Disorders ❑Blood Thinners ❑Progressive Radiculopathy

NOTE: *If you currently have, or have had, one of the above listed conditions, Medicare requires that we advise you that spinal manipulation and other forms of dynamic thrust* ***may be contraindicated*** *in your condition. By signing below, you consent to care and agree to inform this office if another health care provider tells you that you have one of these conditions.*

❑_____

Absolute Contraindications:

Do you have any of the following conditions?

❑Rheumatoid Arthritis ❑Ankylosing Spondylitis ❑Ligament Laxity ❑Joint Dislocation ❑Recent/Unstable Joints ❑Unstable/Missing Dens at C2 ❑ Spinal Cancer ❑Spinal/Joint Infection ❑Myelopathy/Cauda Equina Syndrome ❑Vertebrobasilar Insufficiency Syndrome ❑Arterial Aneurysm

NOTE: *If you currently have, or have had, one of the above listed conditions, Medicare requires that we advise you that spinal manipulation and other forms of dynamic thrust* ***is absolutely contraindicated*** *in the region of the spine that is affected. By signing below, you agree to inform this office if another health care provider tells you that you have one of these conditions.*

❑_____

Medications/Vitamins: _____

Spinal injuries: _____

Surgeries: _____

Hospitalizations: _____

Last Examination: _____

Previous Chiropractic Care: _____

Other History: _____

Relevant Family History: _____

Diet: _____

Exercise: _____

Occupation/Recreation: _____.

Office Use Only:

Remarks: _____

History Taken By: _____

Reviewed By Doctor: _____

Notes:

_____

_____

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_____

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