

## PATIENT INFORMATION

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex:  Male  Female Age: \_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Social Security #: \_\_\_\_\_

Driver License #: \_\_\_\_\_  
(HIPAA requires us to obtain a copy of your driver's license)

Occupation: \_\_\_\_\_

Full-time  Part-time  Unemployed  Retired

Employer: \_\_\_\_\_

Time in This Position: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Children's Names & DOB: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## PAYMENT INFORMATION

Who is responsible for this account? \_\_\_\_\_

Relationship to patient? \_\_\_\_\_

Will you be using insurance?  Yes  No (If no, skip this section)

Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_  
(We need a copy of your insurance card for our records)

Subscriber's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_

### ASSIGNMENT & RELEASE AGREEMENT:

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to Popwell•Scota Spine Center / Lee Popwell, DC / Joe Scota, DC all insurance benefits, if any, otherwise payable to me for services rendered. 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.

Signature: \_\_\_\_\_

## CONTACT INFORMATION



Home: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Ext: \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_-\_\_\_\_

What is the best time and place to reach you? \_\_\_\_\_

E-mail Address: \_\_\_\_\_  
(Your e-mail is used to send appointment reminders & our bi-weekly newsletter)

### IN CASE OF EMERGENCY, CONTACT:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Ext: \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_-\_\_\_\_

## PATIENT CONDITION

Reason for visit: \_\_\_\_\_

\_\_\_\_\_

When did your symptoms first appear? \_\_\_\_\_

How did your symptoms start? \_\_\_\_\_

\_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Not sure/no change

Average pain intensity: (Please mark circle.)

Last 24 hours: no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain

Past week: no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain

How often do you experience our symptoms?

④ Constantly (76%-100% of the time) ③ Frequently (51%-75%) ② Occasionally (26%-50%) ① Intermittently (0%-25%)

How much have your symptoms interfered with your usual daily activities?

① Extremely ② Quite a bit ③ Moderately ④ A little bit ⑤ Not at all

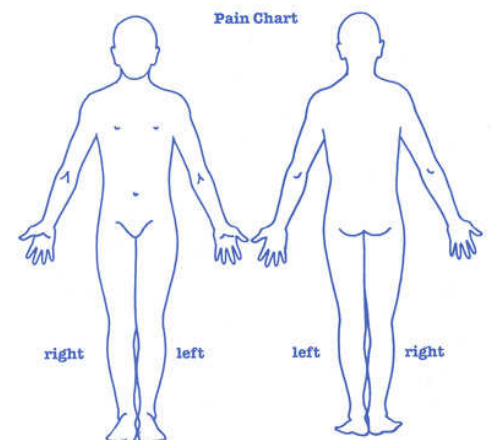
Does it interfere with your:  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform:

Sitting  Standing  Walking  Bending  Lying Down  Other: \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_



(Mark the picture above where you are feeling pain)

# HEALTH HISTORY

Injuries/Surgeries you have had:

	Description	Date
Auto <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____
Slips/Falls <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____
Broken Bones <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____
Surgeries <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____

Previous Chiropractic Physician/Location: \_\_\_\_\_ Last Seen: \_\_\_\_\_

Current Medical Physician/Location: \_\_\_\_\_ Last Seen: \_\_\_\_\_

Other Physician's consulted for this condition: \_\_\_\_\_

Family History of back problems?  No  Yes, Describe: \_\_\_\_\_

Check any treatments you have tried in treating this condition:

Ice  Dry Heat  Moist Heat  Stretching  Massage  Physical Therapy  Bed Rest  Medications  Other: \_\_\_\_\_

Results from treatments: \_\_\_\_\_

List any medications you are currently taking: \_\_\_\_\_

Sleeping Habits:

Position:  Back  Stomach  Left Side  Right Side

Bed Type:  Conventional  Water  Air      Pillows at head? 0 1 2 3      At Knees? 0 1 2 3

Date and facility of last: X-RAY \_\_\_\_\_

MRI \_\_\_\_\_

CT/BONE SCAN \_\_\_\_\_

List if you have a history of other physical conditions? (Diabetes, High Blood Pressure, Arthritis, Cancer, etc.)

Physical Activities you enjoy when healthy:  Stretch  Jog  Walk  Elliptical  Weights  Tennis  Bowl  Golf - Handicap: \_\_\_\_\_

Other: \_\_\_\_\_

## EXERCISE      WORK ACTIVITY      HABITS

<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	Packs/Day: _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	Drinks/Week: _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine Drinks	Cups/Day: _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress Level	Reason: _____

**WOMEN:** Date of last menses: \_\_\_\_/\_\_\_\_/\_\_\_\_ Number of days in cycle: \_\_\_\_\_ Are you pregnant?  Yes  No  Unsure



Thank you for taking the time to share this information with us. Although no one enjoys such detailed paperwork, we believe it is a valuable exchange between the patient and physician. We hope you will find your encounter, in our office, is taken personally and seriously. We believe that next to one's spiritual and family life, health is the first wealth and if you "ignore your health, it will go away!"

– Dr. Lee Popwell & Dr. Joe Scota, Chiropractic Physicians

Dr. Joe Scota      Dr. Lee Popwell