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 ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain

Past week: no pain ⓪ 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

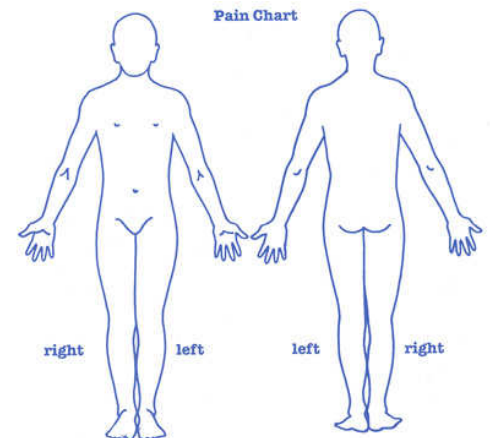
Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

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	☐ Yes ☐ No	______	_____/_____/_____
Slips/Falls	☐ Yes ☐ No	______	_____/_____/_____
Broken Bones	☐ Yes ☐ No	______	_____/_____/_____
Surgeries	☐ Yes ☐ 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	
☐ None	☐ Sitting	☐ Smoking	Packs/Day: ____________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week: ____________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day: ____________
☐ Heavy	☐ Heavy Labor	☐ 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