SEAY WELLNESS

Patient Data **Date** ____

Title: (Check one) □ Mr. □ Mrs. □Ms. □ Miss □ Dr. □ Other _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____) _____-_____ **Work Phone (_____)** _____-_____

Cell Phone (_____) _____-_____ **Email** _____

Date of Birth _____/_____/_____ **Sex:** □ Male □ Female

Social Security Number: _____-_____-_____ **Marital Status:** □ Single □ Married □ Other

Employment Status: □ Employed □ Unemployed □ FT Student □ PT Student □ Other_____

Spouse Data ____

First Name _____ **Middle Initial** _____ **Last Name** _____

Home Phone (_____) _____-_____ **Work Phone (_____)** _____-_____

Employer Data ____

Name _____

Your Occupation _____ **Your Job Description** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Emergency Contact ____

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (_____) _____-_____ **Cell Phone (_____)** _____-_____

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Patient Name_____ **Date**_____

How did you hear about our office? _____

Medical Conditions: (Check all that apply to you)

□ Arthritis	□ Cancer	□ Diabetes	□ Heart Disease
□ Hypertension	□ Psychiatric Illness	□ Skin Disorder	□ Stroke
□ Lyme Disease	□ Fibromyalgia	□ Autoimmunity	□ Other _____

Surgeries: (Check all that apply to you)

□ Appendectomy	□ Cardiovascular procedure	□Cervical spine	□ Hysterectomy
□ Joint Replacement	□ Prostate	□ Lumbar spine	□ Gall Bladder
□ Brain	□ Shoulder	□ Thoracic spine	□ Knee
□ Carpal Tunnel	□ Gastro-intestinal	□ Uro-genital	□ Hernia
□ Other _____			

Allergies: (Check all that apply to you)

□ Eggs	□ Fish and Shellfish	□ Milk or Lactose	□ Peanuts
□ Soy	□ Sulfites	□ Wheat/Glutens	□ Other _____

Social History: (Check all that apply to you)

Caffeine use:	□ occasional	□ often	□ never
Drink Alcohol:	□ occasional	□ often	□ never
Exercise:	□ occasional	□ often	□ never
Chew Tobacco:	□ occasional	□ often	□ never
Cigarettes:	□<1 pack/day	□ >1 pack/day	□ never
Wear Seat Belts:	□ occasional	□ always	□ never

Other _____

Family History: (Check all that apply)

Arthritis:	□ Parent	□ Sibling	Parkinson's:	□ Parent	□ Sibling
Cancer:	□ Parent	□ Sibling	Alzheimer's:	□ Parent	□ Sibling
Diabetes:	□ Parent	□ Sibling	Lyme Disease:	□ Parent	□ Sibling
Heart Disease	□ Parent	□ Sibling	Multiple Sclerosis:	□ Parent	□ Sibling
Hypertension	□ Parent	□ Sibling	Mental Illness:	□ Parent	□ Sibling
Stroke	□ Parent	□ Sibling			
Thyroid	□ Parent	□ Sibling			

Other _____

Occupational Activities: (Check one that best describes your job description)

□ Administration	□ Business Owner	□ Clerical/Secretary	□ Computer User
□ Heavy Equipment operator	□ Daycare/Childcare	□ Construction	□ Health Care
□ Food Service Industry	□ Medium Manual Labor	□ Manufacturing	□ Home Services
□ Heavy Manual Labor	□ Light Manual Labor	□ Executive/Legal	□ Housekeeper
□ Other _____			

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Patient Name_____ **Date**_____

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Ear Ringing			
Frequent Urination				Depression				Sinus Infections			
Blood in Urine				Anxiety							
Kidney Stones				Stress				**Gastrointestinal**			No
Lower Side Pain									Past	Present	
				Endocrine			No	Gall Bladder Problems			
Neurologic			No		Past	Present		Bowel Problems			
	Past	Present		Thyroid				Constipation			
Stroke				Diabetes				Liver Problems			
Seizures				Hair Loss				Ulcers			
Head Injury				Menopausal				Diarrhea			
Brain Aneurysm				Menstrual				Nausea/Vomiting			
Numbness								Bloody Stools			
Severe Headaches				**Hematologic**			No	Poor Appetite			
Pinched Nerves					Past	Present					
Parkinson's				Hepatitis				**Musculoskeletal**			No
Carpal Tunnel				Blood Clots					Past	Present	
Vertigo				Cancer				Gout			
				Bruising				Arthritis			
Constitutional			No	Bleeding				Joint Stiffness			
	Past	Present		Fever, Chills				Muscle Weakness			
				Sweating				Osteoporosis			
Weight Loss/Gain								Broken Bones			
Low Energy Level								Joints Replaced			
Difficulty Sleeping											

Please list all current medications being taken _____

_____

_____

Please list all current supplements being taken _____

_____

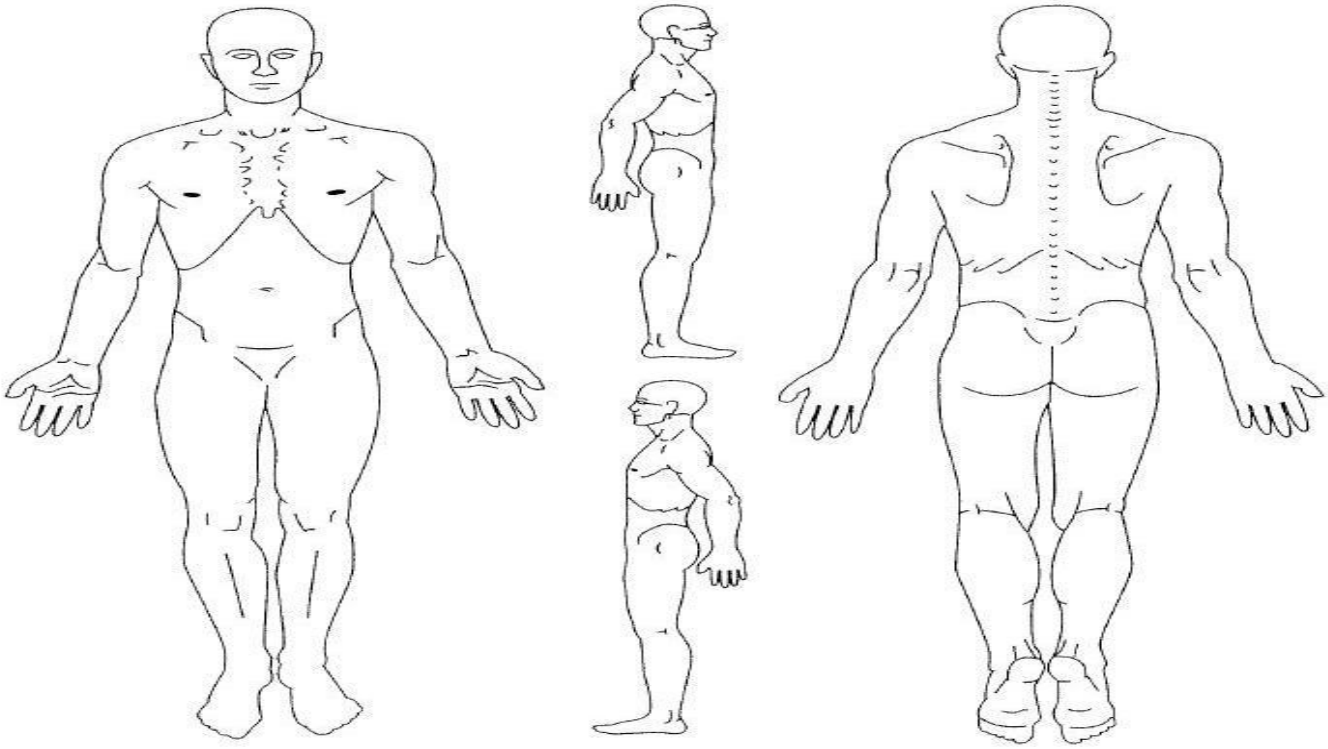
SEAY WELLNESS

Patient Name **Date**

Are you pregnant? Yes_____ No _____N/A_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

_____

_____

When did your symptoms begin? Month_____ Day_____Year _____

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐Work related Accident ☐ Other_____

How did your symptoms begin? _____

_____

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)

What describes the nature of your symptoms?

☐ Sharp ☐ Dull ache ☐ Numb ☐ Shooting
☐ Burning ☐ Tingling ☐ Stabbing ☐ Other _____

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Patient Name **Date**

How are your symptoms changing?

☐ Getting better ☐ Not changing ☐ Getting worse

Employment, ADL, and Recreation Information

Outcomes Assessment Tool Used _____ **Score** _____

Description of Work: _____

Condition's Effect On Job Performance: ☐ **No Effect** ☐ **Mild** (painful can do) ☐ **Mod** (painful limited ability) ☐ **Mod/Sev (**limited duty) ☐ **Sev (**no limited duty) ☐ **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Care –Infirm Family:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Carrying Groceries:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Change Posn–Sit-Stand:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Climb Stairs:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Driving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Extended Computer Use:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Feeding:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Household Chores:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Kneeling:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lift Children:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Pet Care:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Reading (Concentration):	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Bathing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Dressing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Shaving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sexual Activities:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sleep:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Sitting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Standing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Walking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Yard Work:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
_____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
_____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform

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Patient Name_____Date_____

Payment/Insurance Information:

Who is responsible for your bill? □ Self □ Health Insurance □ Spouse □ Worker's Comp
□ Auto Insur. □ Medicare □ Medicaid □ Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Primary Care Physician _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? □Yes □No Date: ____/____/____ Time: _____am / pm

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____
Date_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____
Date_____

SIGNATURE OF PHYSICIAN: _____Date: _____