SCOTT CHIROPRACTIC CENTER

8805 KINGSTON PIKE SUITE 105 • KNOXVILLE • TENNESSEE 37923 • TEL: (865)-693-1911

Name: _____ Marital Status: S M D W Date of Birth: _____/_____/_____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Referred by: _____ Email: _____

Occupation: _____ Employer: _____

Employer Address: _____ City: _____State: _____ Zip: _____

Height: _____ Weight: _____ Preferred Language:_____ Tobacco Use: Type/frequency_____

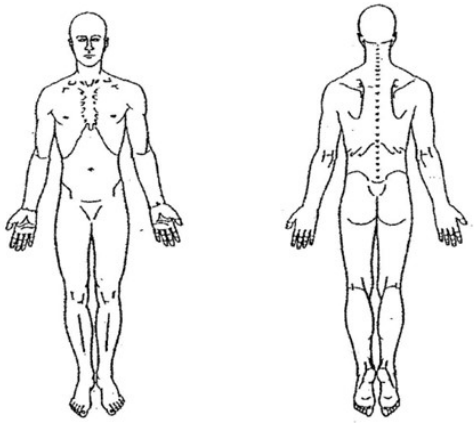
1. Describe your **MAJOR** complaint? _____Date problem began? _____
2. How did this problem begin (falling, lifting, not sure, etc.)? _____
3. Have you had this condition in the past? □ YES □ NO If yes, when?_____
4. How often do you experience your symptoms?
   □ 76-100% (Constant) □ 51-75% (Frequent) □ 26-50% (Occasional) □ 0-25% (Intermittent) □ On & off □ Random □ Recurring
5. Describe the nature of your symptoms: □ Sharp □ Dull □ Ache □ Sore □ Numb □ Burning □ Shooting □ Tingling □ Tightness □ Stabbing
   □ Throbbing □ Other: _____
6. Do your symptoms radiate? □ YES □ NO If yes, where?_____
7. Please rate your pain on a scale of 1-10 (0= no pain, 10= excruciating pain) □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
9. Overall, is you're major complaint? □ Getting better □ Staying the same □ Getting worse
9. What activities aggravate your condition (working, exercise, etc)? _____
10. What makes your pain better (ice, heat, massage, etc)? _____
11. Have you had previous care for this condition? □ YES □ NO If yes, what? _____
12. Have you had any recent diagnostic tests for this complaint? □ YES □ NO If yes, what? _____

1. Describe your **SECOND** complaint? _____Date problem began? _____
2. How did this problem begin (falling, lifting, not sure, etc.)? _____
3. Have you had this condition in the past? □ YES □ NO If yes, when?_____
4. How often do you experience your symptoms?
   □ 76-100% (Constant) □ 51-75% (Frequent) □ 26-50% (Occasional) □ 0-25% (Intermittent) □ On & off □ Random □ Recurring
5. Describe the nature of your symptoms: □ Sharp □ Dull □ Ache □ Sore □ Numb □ Burning □ Shooting □ Tingling □ Tightness □ Stabbing
   □ Throbbing □ Other: _____
6. Do your symptoms radiate? □ YES □ NO If yes, where?_____
7. Please rate your pain on a scale of 1-10 (0= no pain, 10= excruciating pain) □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
9. Overall, is you're major complaint? □ Getting better □ Staying the same □ Getting worse
9. What activities aggravate your condition (working, exercise, etc)? _____
10. What makes your pain better (ice, heat, massage, etc)? _____
11. Have you had previous care for this condition? □ YES □ NO If yes, what? _____
12. Have you had any recent diagnostic tests for this complaint? □ YES □ NO If yes, what? _____

List your **Family History**: Please answer the following questions with the following below or □ **None**

__ Cancer __ Diabetes __ High Blood Pressure __ Heart Problems/Stroke __Neurological Condition __ Rheumatoid Arthritis

If you are in pain, please mark the exact location of your pain on the diagram below.



Check appropriate squares (x) past or (✓) present condition

- ❑Headaches
- ❑Nervousness
- ❑Insomnia
- ❑Head colds
- ❑High blood pressure
- ❑Migraines
- ❑Nervous breakdown
- ❑Chronic tiredness
- ❑Dizziness
- ❑Sinus troubles
- ❑Eye problems
- ❑Excessive sweating
- ❑Ear ache
- ❑Ulcers
- ❑Stomach troubles
- ❑Indigestion
- ❑Heartburn
- ❑Gastritis
- ❑Lowered resistance
- ❑Diabetes
- ❑Mental, emotional conditions
- ❑Convulsions
- ❑Acne
- ❑Eczema
- ❑Hay fever
- ❑Adenoids
- ❑Hearing loss
- ❑Ringing ear
- ❑Laryngitis
- ❑Hoarseness
- ❑Sore throat
- ❑Tonsillitis
- ❑Croup
- ❑Poor circulation
- ❑Swollen ankles
- ❑Cold fee
- ❑Weakness in legs
- ❑Leg Cramps
- ❑Hemorrhoids (piles)
- ❑Bursitis
- ❑Thyroid condition
- ❑Asthma
- ❑Cough
- ❑Difficulty breathing
- ❑Shortness of breath
- ❑Heart condition
- ❑Bronchitis
- ❑Pleurisy
- ❑Pneumonia
- ❑Congestion
- ❑Influenza
- ❑Gall bladder condition
- ❑Jaundice
- ❑Shingles
- ❑Liver condition
- ❑Fever
- ❑Low blood sugar
- ❑Arthritis
- ❑Kidney troubles
- ❑Constipation
- ❑Colitis
- ❑Dysentery
- ❑Diarrhea
- ❑Ruptures
- ❑Hernias
- ❑Cramps
- ❑Varicose veins
- ❑Bladder troubles
- ❑Menstrual problems
- ❑Miscarriages
- ❑Bed wetting
- ❑Impotency
- ❑Change of life symptoms
- ❑Knee pain
- ❑Sciatica
- ❑Difficult urination
- ❑Painful urination
- ❑Frequent urination

PATIENT AUTHORIZATION REGARDING OPEN DOOR ADJUSTING ENVIRONMENT AND USE OF PATIENT RECORD OF DISCLOSURES

Our office provides care in both private rooms and an "open door" adjusting environment. Some adjustments are done in an open adjusting area and as a result patients are in sight of each other and some ongoing routing details of care may be in earshot of other patients and staff. This environment just as private adjustment rooms, is used for ongoing care and is not the environment for taking patients histories, performing examinations or presenting report of findings. These procedures are done in a private, confidential setting. If you choose not to be adjusted in an open-door adjusting environment, we will utilize our private adjusting rooms. Your signature below indicates your authorization for this activity.

Patient/Guardian Signature: _____ Date: _____

People see Chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your program of care. Please check the type of care desires so that we may be guided by your wishes whenever possible.

- ❑ RELIEF CARE: Symptomatic relief of pain or discomfort
- ❑ CORRECTIVE CARE: Correcting and relieving the cause of the problem as much as possible as well as the symptoms
- ❑ COMPREHENSIVE CARE: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic Care
- ❑ I want the Doctor to select the type of care appropriate for my condition

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient/Guardian Signature: _____ Date: _____