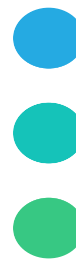
dawson

SPINAL CARE & HEALTH CENTER



Patient Information:

Patient Full Name:			Date:	Gender:
Address:			Employer:	Work Phone:
City:	State:	Zip:	Work Address:	
Home Phone:	Cell Phone:		Spouse Name:	Spouse Phone:
Date of Birth:			Primary Care Physician:	
Email Address:			Marital Status: ☐ S ☐ M ☐ D ☐ W	

I would like to receive reminders:
☐ Text ☐ Email

Cell Phone Carrier: ______________________________

☐ I do not wish to receive the newsletter/promotions.

☐ I give permission to leave a message.

If filling out paperwork for your child:

Parent/Legal Guardian:	Address (if different from your child):		
Phone (if different from your child):	City:	State:	Zip:

Emergency Contact/Referral Source:

Emergency Contact Name:		How did you hear about our office?
Relationship to Patient:		Please list source. (ie: John Doe, Google, etc.)
Home Phone:	Cell Phone:	Are you a prior patient?

*Medicare Part B Patients Only:

Medicare ID Number:	Medical Part B Effective Date:

***Please present your Medicare card so we can keep a copy on file. Additional forms to follow.**

Health History:

Current Condition/Reason for Visit: Date Pain/Symptoms Began:________________

____

____

What triggered the onset of symptoms?

____

____

Have you had this problem before? ☐ Yes ☐ No Is your condition getting progressively worse? ☐ Yes ☐ No

Do you have a diagnosed medical condition(s)? ☐ Yes ☐ No
If so, please list: ____

____

Is this condition worse at certain times of the day/night? ☐ Yes ☐ No
If so, please describe: ____

____

Do you have pain that shoots, radiates, or is intermittent? ☐ Yes ☐ No
If so, please describe: ____

____

For office use only

Height: ________________

Weight: ________________

BP: ____________________

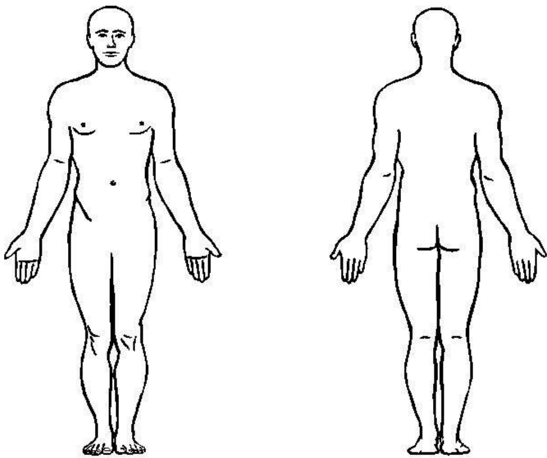
Pulse: __________________

What other treatments have you had for this condition? (check all that apply)

☐ Chiropractic ☐ Orthopedic ☐ Neurologist ☐ Physical Therapy
☐ Medication ☐ Surgery ☐ Other: ___________________

Indicate areas of pain on the chart below:

Numbness	===	Knot	###
Dull Ache	000	Burning	XXX
Sharp/Stabbing	^^^	Pins & Needles	+++
Other ________	///		



Please rate the severity of your pain on a scale from 0 – 10: 0=no pain, 10=severe pain

1 2 3 4 5 6 7 8 9 10

Have you ever been in a motor vehicle accident? ☐ Yes ☐ No
If so, please describe: ____

____

Do you have a pace maker? ☐ Yes ☐ No

What activities worsen?

☐ Sleeping ☐ Bending
☐ Walking ☐ Reaching
☐ Running ☐ Driving
☐ Eating ☐ Stretching
☐ Other ____________

This condition is interfering with?

☐ Sleeping ☐ House Chores
☐ Work ☐ Exercise
☐ Hobbies ☐ Driving
☐ Eating ☐ Relationships
☐ Other ____________

What are your health goals?

☐ Remove pain
☐ Gain more energy/stamina
☐ Restore health/reduce illness
☐ Achieve optimal wellness
☐ Other:____________

Please indicate your exposure to the following therapies:

☐ Chiropractic Care – If so, date of last visit:______________
☐ Nutritional Supplementation
☐ Massage Therapy
☐ Medicinal Herbs
☐ Acupuncture
☐ Homeopathy
☐ Other: ______________

1. Regarding your birth process:		Patient Comment	Practitioner's Comment (Office Use)
Was the delivery long/difficult?	Y☐ N☐		
Forceps or extraction used?	Y☐ N☐		
Breast Fed?	Y☐ N☐		

2. Childhood Growth:		Patient Comment	Practitioner's Comment (Office Use)
Vaccinated?	Y☐ N☐		
Have childhood illnesses?	Y☐ N☐		
Early childhood fall or injury?	Y☐ N☐		
Ear infections/Colic/Asthma?	Y☐ N☐		
ADD or ADHD?	Y☐ N☐		
Antibiotics administered?	Y☐ N☐		
Drugs (Rx, OTC, recreational?)	Y☐ N☐		
Surgeries?	Y☐ N☐		
Hospitalizations for illness?	Y☐ N☐		
Sports or physical activities?	Y☐ N☐		
Injuries during sports?	Y☐ N☐		
Auto/sport vehicle accidents?	Y☐ N☐		
Did you have other traumas?	Y☐ N☐		
Did you ever break any bones?	Y☐ N☐		

3. Current/Past Health Habits (check ☐ for past use):				
Drink alcohol?	Past ☐	Y☐ N☐	How often?	
Drink coffee?	Past ☐	Y☐ N☐	How often?	
Drink water?	Past ☐	Y☐ N☐	How much?_____ Ounces per day	
Daily sweets?	Past ☐	Y☐ N☐	How often?	
Sugar substitutes?	Past ☐	Y☐ N☐	How often?	
Dieting or cleansing?	Past ☐	Y☐ N☐	How often?	
Smoke cigarettes?	Past ☐	Y☐ N☐	How often?	
Chew tobacco?	Past ☐	Y☐ N☐	How often?	
Recreational drugs?	Past ☐	Y☐ N☐	How often?	
OTC drug use?	Past ☐	Y☐ N☐	How often?	
Prescription drugs?	Past ☐	Y☐ N☐	How often?	
Meditation/prayer?	Past ☐	Y☐ N☐	How often?	
Exercise regularly?	Past ☐	Y☐ N☐	How often?	
Sleep irregularity?	Past ☐	Y☐ N☐	Hrs of sleep/night?	
Occupational stress?	Past ☐	Y☐ N☐	☐ Physical ☐ Emotional	
Relationship stress?	Past ☐	Y☐ N☐	☐ Physical ☐ Emotional	
Drive long distances?	Past ☐	Y☐ N☐	How often?	

Sleep on or wear magnets?	Past ☐	Y☐ N ☐	How often?	
Wear a shoe lift or orthotic?	Past ☐	Y☐ N ☐	How often?	
Sleep position?	Indicate Position		☐ Side ☐ Stomach ☐ Back	

4. Current/Past Health History (check ☐ for past use):			**Patient Comment**	**Practitioner's Comment (Office Use)**
Dental/gum problems?	Past ☐	Y☐ N ☐		
Eye/vision problems?	Past ☐	Y☐ N ☐		
Hearing problems?	Past ☐	Y☐ N ☐		
Headaches or Migraines?	Past ☐	Y☐ N ☐		
Tinnitus/ringing in ears?	Past ☐	Y☐ N ☐		
Depression/mental illness?	Past ☐	Y☐ N ☐	Family History? Y☐ N ☐	
Air hunger/deep sighs?	Past ☐	Y☐ N ☐		
TMJ/locking of the jaw?	Past ☐	Y☐ N ☐		
Broken bones?	Past ☐	Y☐ N ☐		
Torn ligaments?	Past ☐	Y☐ N ☐		
Heartburn/reflux?	Past ☐	Y☐ N ☐		
High/low blood pressure?	Past ☐	Y☐ N ☐		
High cholesterol?	Past ☐	Y☐ N ☐	Family History? Y☐ N ☐	
Diabetes?	Past ☐	Y☐ N ☐	Family History? Y☐ N ☐	
Hypoglycemia?	Past ☐	Y☐ N ☐		
Asthma?	Past ☐	Y☐ N ☐		
Allergies?	Past ☐	Y☐ N ☐		
Respiratory infections?	Past ☐	Y☐ N ☐		
Sinus infections?	Past ☐	Y☐ N ☐		
Heart attack?	Past ☐	Y☐ N ☐	Family History? Y☐ N ☐	
Stroke?	Past ☐	Y☐ N ☐	Family History? Y☐ N ☐	
Mono/other serious virus?	Past ☐	Y☐ N ☐		
Cold hands/feet?	Past ☐	Y☐ N ☐		
Weight loss/gain?	Past ☐	Y☐ N ☐		
Hyper/Hypothyroidism?	Past ☐	Y☐ N ☐		
Arthritis?	Past ☐	Y☐ N ☐		
Colitis/Crohn's/IBS?	Past ☐	Y☐ N ☐		
Frequent constipation?	Past ☐	Y☐ N ☐		
Frequent diarrhea?	Past ☐	Y☐ N ☐		
Grind Teeth?	Past ☐	Y☐ N ☐	Awake ☐ Sleeping ☐	
Irregular menses?	Past ☐	Y☐ N ☐		
Miscarriage/infertility?	Past ☐	Y☐ N ☐	Family History? Y☐ N ☐	
Sleep problems?	Past ☐	Y☐ N ☐		
Cancer?	Past ☐	Y☐ N ☐	Family History? Y☐ N ☐	
Heart Disease?	Past ☐	Y☐ N ☐	Family History? Y☐ N ☐	
Epilepsy?	Past ☐	Y☐ N ☐		
Sciatica?	Past ☐	Y☐ N ☐		
Prostate Problems?	Past ☐	Y☐ N ☐		
STD's?	Past ☐	Y☐ N ☐		

Poor Circulation?	Past ☐	Y☐ N ☐		
Vertigo/Dizziness?	Past ☐	Y☐ N ☐		
Ulcer/Hernia?	Past ☐	Y☐ N ☐		
Thyroid Problems?	Past ☐	Y☐ N ☐		
Shingles?	Past ☐	Y☐ N ☐		
Kidney Problems?	Past ☐	Y☐ N ☐		
Bladder Problems?	Past ☐	Y☐ N ☐		
Digestion Problems?	Past ☐	Y☐ N ☐		
Hemorrhoids?	Past ☐	Y☐ N ☐		
Herniated Disk?	Past ☐	Y☐ N ☐		
Osteoporosis?	Past ☐	Y☐ N ☐		
Menopause?		Y☐ N ☐		
AIDS/HIV?		Y☐ N ☐		

Category:	**Please list any details for the following:**
Prescription Medications: ☐ No Rx Medications	
Over-the-counter Drugs: ☐ No OTC Medications	
Allergies (food, airborne, chemical, etc.): ☐ No Allergies	
Vitamins, herbs, teas, homeopathy or other natural supplements: ☐ No Supplements	
Surgeries or Medical Procedures **(last 12 months):** ☐ No Recent Surgeries	☐ Gallbladder Removed
Surgeries or Medical Procedures **(> 12 months):** ☐ No Prior Surgeries	☐ Gallbladder Removed

Ethnicity:	Race:	Eating Preference:
☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to State Preferred Language: _________________	☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Decline to State	☐ Vegan ☐ Vegetarian ☐ Dairy-Free ☐ Low Carb ☐ Wheat-Free ☐ Gluten-Free ☐ Low/No Sugar ☐ No Restriction ☐ Other Restriction _____________

A. ☐ I am pregnant.
B. ☐ I am not pregnant. My last menstruation started:________________
C. ☐ My child is not pregnant. Her last menstruation started:________________
D. ☐ Not applicable

Additional notes from patient regarding history/health: ____

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____

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____

Service & Fee Schedule:

New Patient Exam, X-Rays, First Correction	$425.00	Office Visit w/ Correction	$55.00
New Patient Child (3-12 years)	$275.00	Child Office visit w/ Correction (12 & under)	$30.00
New Patient Infant (0-2 years)	$30.00	New Patient Consultation	Free
New Patient BioMeridian Scan w/ biotouch	$100.00	BioMeridian Scan Follow-Up	$100.00

Other Charges:

Office Visit; No Correction	Free	Missed Appointment (1st time is gifted)	$55.00
Chart Copying	$.25/page	Returned Check	$25.00
Transferring/Mailing Records	Cost of Postage	Hair Analysis	$100.00

*Nutritional Supplements, educational material and other natural products are not included in these fees.

Insurance:

We are a cash practice only; therefore, we do not accept any insurance plans except Medicare Part B orignial. If you are on Medicare Part B original, you will need to complete additional forms to submit your claim.

Questions:

Our staff is here to help you achieve your healthcare goals and educate you and your family for the future. Dr. Dawson will answer any questions you may have about examination findings, test results and reports. All questions are important and you are encouraged to voice them.

Authorization: (Please read & initial each statement)

1. _______ I authorize Dr. Dawson to perform chiropractic exams, adjustments and procedures, including diagnostic x-rays for detecting and correcting body imbalance and subluxations of the spine.
2. _______ I authorize Dr. Dawson to exchange information or release office records to process third party or insurance claims.

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health. I have read the above statements regarding services, treatment and finances. I understand the Doctor's objectives pertaining to my/my child's care in this office. I also provide consent for clinical reports and results of my case to be used for advancing clinical knowledge, research and scientific purposes, provided my identity is concealed.

Patient Name (print): ______________________________ Date: ____________

Patient Signature: ______________________________ ☐ If signing for minor

Name of Child: ______________________________ Age: ________ Relation: ____________