Katy Chiropractic Diagnostic and Treatment Center 505 South Mason Road, Katy, Texas 77450   281-579-1116

Today's Date	Whom May we Thank for Referring You?	No Yes When? Have you consulted a Chiropractor before?

Patient Name	Last	First	MI	Gender	Male	Female	Patient Date of Birth

Patient Address	City	State	Zip

Home Phone	Cell Phone	Work Phone	E-mail

Marital Status:	Single	Married	Divorced	Widowed	Separated

Emergency Contact	Relationship	Phone	Primary Care Provider's Name

Employer	Occupation	Name of the person whose insurance you are filing on

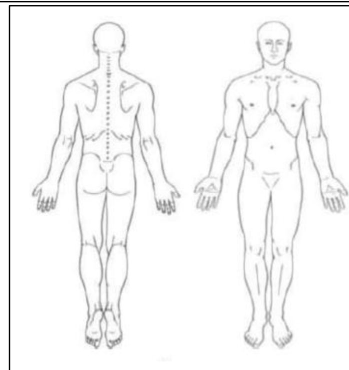
Patient Insurance ID# /or Social Security Number	Health Plan	Group #

1. Date your current symptoms started:

2. Briefly describe your symptoms:

3. How did your symptoms start?

Indicate where you have symptoms



Symptom Quality:
☐ Sharp
☐ Stabbing
☐ Dull
☐ Stiffness
☐ Aching
☐ Burning
☐ Shooting
☐ Numb
☐ Tingling
☐ Cramping
☐ Throbbing
☐Nagging

4. Pain intensity: **Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 unbearable pain**
Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 unbearable pain

5. How often do you experience your symptoms?

☐ Constant(76-100% of the time) ☐Frequent(51-75%) ☐Occasional (26-50%) ☐Intermittently(0-25%)

6. Aggravating or relieving factors:

What makes it worse?
What have you tried? ☐Prescription ☐OTC drugs ☐Surgery ☐Acupuncture ☐Chiropractic ☐Massage ☐Physical therapy ☐Ice ☐Heat
How much did it help?

7. How much have your symptoms interferes with your usual daily activities? (both at home and work)

0 1 2 3 4 5 6 7 8 9 10
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. How is your condition changing since care began at this facility?

☐ N/A- Initial visit for this episode ☐ Much Worse ☐ little Worse ☐ No change☐ A little better ☐ Better ☐ Much Better

9. In general, would you your overall health right now is…

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

10. Back Pain Index: How does your condition affect you ranging from 0 (none or no affect) to 5 (totally or affects severely)

Pain Intensity: ---------------- none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe
Sleeping: ---------------------- none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe
Sitting: ------------------------- none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe
Standing: ---------------------- none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe
Walking: ----------------------- none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe
Personal Care: ---------------- none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe
Lifting: ------------------------- none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe
Traveling: ---------------------- none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe
Social Life: --------------------- none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe
Changing degree of Pain: -- none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe

11. Neck Pain Index: How does your condition affect you ranging from 0 (none or no affect) to 5 (totally or affects severely)

Pain Intensity: -------------- none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe
Sleeping: --------------------- none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe
Reading: ---------------------- none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe
Concentration: ------------- none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe
Work: ------------------------- none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe
Personal Care: -------------- none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe
Lifting: ------------------------ none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe
Driving: ----------------------- none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe
Recreation: ------------------ none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe
Headaches: ------------------ none 0 ------- 1 --------- 2 ---------- 3 ---------- 4 ---------- 5 severe

REVIEW OF SYSTEMS:

GENERAL APPEARANCE

□ Weight Loss
□ Weight Gain
□ Change in Sleeping Patterns
□ Change in Activity Capacity

NEUROLOGICAL

□ Anxiety
□ Headaches
□ Depression
□ Meningitis
□ Paralysis
□ Seizure
□ Stroke
□ Tingling
□Tremors
□ Memory Loss
□ Fainting spells
□ Dizziness
□ Head injuries
□ Blackouts or near blackouts
□ Change in sensation anywhere on your body
□ Localized weakness or numbness

EARS, EYES, NOSE, & THROAT

□ Hay fever
□ Glaucoma
□ Polyps
□ Allergy
□ Cataracts
□ Goiter
□ Hoarseness
□ Double vision
□ Gum problems
□ Eye problems
□ Ear Infections
□ Glasses/contacts
□ Hearing Loss
□ Ear discharge/pain
□ Frequent nosebleeds
□ Ringing in your ears
□ Sinus infections
□ Swollen glands

CARDIOVASCULAR

□ Angina
□ Leg cramps
□ Ankle swelling
□ Awakening at night short of breath & getting out of bed
□ Cardiac catheterization
□ Cold hands or feet
□ Congenital heart defects
□ Dizziness when standing up quickly
□ Heart attacks
□ Heart failure
□ High or low blood pressure
□ Irregular heart rate
□ Purple fingers or lips
□ Leg pain that resolves with rest
□ Heart palpitations
□ Varicose veins
□ Chest pains
□ Murmurs

RESPIRATORY

□ Asthma
□ Breathlessness when lying flat
□ Prolonged cough
□ Coughing up blood
□Emphysema
□ Shortness of breath
□ Tuberculosis
□ Pneumonia
□ Frequent infections (bronchitis)
□ Wheezing
□ Pleurisy

SKIN

□ Abscess
□ Dandruff
□ Acne
□ Oily skin
□ Boils
□ Rashes
□ Hives
□ Dry skin
□ Lumps
□ Psoriasis
□ Jaundice
□ Athlete's foot
□ Excessive body odor
□ Excessive sweating
□ Fungal infections
□ Nail problems
□ Moles irregular
□ Moles - change/new

KIDNEYS & URINARY TRACT

□ Blood in urine
□ Brown urine
□ Dribbling after urination
□ Painful urination
□ Excessive thirst
□ Involuntary urination/incontinence
□ Urinating frequently (day)
□ Urinating frequently (night)
□ Urine hesitancy
□ Weak flow
□ Frequent bladder infections
□ Kidney disease
□ Kidney stone

ENDOCINE

□ Diabetes
□ Sickle cell
□ Abnormal body hair
□ Changes in skin texture
□ Cold intolerance
□ Heat intolerance
□ History of "borderline" diabetes

MUSCULOSKELETAL

□ Anemia
□ Arthritis
□ Back pain
□ Bursitis
□ Gout
□ Joint aches
□ Neck pain
□ Tendinitis
□ Abnormal Blood Counts

- ☐ Blood clots in legs/lungs
- ☐ Bone Marrow Biopsy
- ☐ Easy Bleeding
- ☐ Easy bruising
- ☐ Joint swelling
- ☐ Morning stiffness
- ☐ Muscle aches

GASTROINTESTINAL

- ☐ Diarrhea
- ☐ Reflux
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Abdominal pain
- ☐ Anal fissures
- ☐ Black tarry stools
- ☐ Vomiting blood
- ☐ Constipation
- ☐ Nausea
- ☐ Problems swallowing
- ☐ Hiatal Hernia
- ☐ Intestinal obstruction
- ☐ Liver disease
- ☐ Hemorrhoids
- ☐ Red blood after bowel movements
- ☐ Gallstones
- ☐ Vomiting
- ☐ Heartburn
- ☐ Indigestion

MALE & FEMALE

- ☐ Painful sexual intercourse
- ☐ Loss of sexual interest
- ☐ Unprotected sex
- ☐ Groin itching
- ☐ Sexually transmitted diseases

MALES ONLY

- ☐ Hernia
- ☐ Sterility
- ☐ Bloody ejaculation
- ☐ Inability to complete intercourse
- ☐ Lump on testicle
- ☐ Penile discharge
- ☐ Problems maintaining or keeping an erection
- ☐ Prostate disease
- ☐ Sores on penis or warts
- ☐ Testicular pain
- ☐ Testicular swelling

FEMALES ONLY

- ☐ D & C
- ☐ Hot flashes
- ☐ Hernia
- ☐ Fibroids
- ☐ Abnormal bleeding between cycles
- ☐ Abnormal pap smear
- ☐ Bleeding after intercourse
- ☐ Complications w/pregnancy
- ☐ PMS
- ☐ Endometriosis
- ☐ Heavy bleeding during cycles
- ☐ Discharge from breast
- ☐ Ovarian cysts
- ☐ Pelvic Inflammatory Disease
- ☐ Postmenopausal symptoms
- ☐ Vaginal discharge
- ☐ Vaginal Dryness
- ☐ Vaginal warts

Not Listed Above:

☐ **I instruct the doctors of chiropractic and staff at Dr. Vitek's office to provide chiropractic care that in the doctor's professional judgment is the best care to help me return to a state of health. This office does not proclaim to cure any disease. If the doctor does not believe that we can help your condition, you will not be treated and will be referred out for that condition.**

☐ **I may request a copy of the HIPPA privacy policy and I understand that it describes how my personal health information is protected and that it allows for this office to release such information when seeking reimbursement from an insurance company or other related third party.**

☐ **I realize that X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of my last menstrual period: _________________________________.**

☐ **I understand this office accepts insurance assignment and that co-payment and deductibles are due at the time service is rendered. This office will estimate the amount I am to pay based on current knowledge of my insurance companies negotiated rates. I may owe more or less as determined by the explanation of benefits. I acknowledge that any insurance I may have is an agreement between the insurance company and me and that I am responsible for the payment of any service I receive that is not covered by the insurance company. There is a $25 charge for returned checks and missed appointments.**

I affirm the above is true.

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Patient's name printed *patient signature* date

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Reviewed by (provider's signature) date