



**Patient History Form**

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Nick Name: \_\_\_\_\_ Social #: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Apt #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_

Do you prefer to be reached by:  Email  Telephone  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F  
Are you:  Minor  Single  Married  Divorced  Widowed  
Spouse Name: \_\_\_\_\_  
Number of Children: \_\_\_\_\_ Children's Names: \_\_\_\_\_  
Employment Status:  Full time  Part time  Retired  Unemployed  Student  Other  
Your Employer: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_  
If you are a College Student are you?:  Full time  Part time  
Financially Responsible Party:  Self  Spouse  Parent  Other  
Emergency Contact: (Name, Phone #) \_\_\_\_\_

**Responsible Party**

Name of Person Responsible for this account: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Phone # \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Name of employer: \_\_\_\_\_ Work # \_\_\_\_\_

**REFERRAL SOURCE**

Were you referred by a patient of ours?  Yes  No  
Patient's Name: \_\_\_\_\_  
Were you referred by the internet?  Yes  No  
If so, any particular directory or site? \_\_\_\_\_  
Were you referred by:  Doctor Referral  Lecture / Screening  MAC  Other:  
If so by who? \_\_\_\_\_

**General Insurance Information**

*We will help you in any way we can for you to file your Insurance claim, however we do not accept insurance reimbursements for Sports Chiropractic Services. In the past, we have seen patients get back an average of 60-80% from there insurance carriers, If they have a PPO plan, and after the deductible is meet. For more info on why we do not take insurance please refer to our website.*

Name on the Insurance: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Phone #: \_\_\_\_\_ PPO / HMO / Other \_\_\_\_\_  
How much is your Out of Network Deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_  
Maximal Annual Out of Network Benefits: \_\_\_\_\_

## Symptoms

Reason for the visit: \_\_\_\_\_  
When did you first notice the Symptoms? \_\_\_\_\_  
Is this condition getting progressively worse? \_\_\_\_\_  
Where specifically is the problem(s) located? \_\_\_\_\_  
Which activities are difficult to perform?  Sitting  Standing  Walking  Bending  Other  
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  Burning  
 Tingling  Cramps  Stiffness  Swelling  Other  
Rate the severity of your pain ( 0 none..5 moderat..10 severe pain) 0 1 2 3 4 5 6 7 8 9 10  
Is the pain constant or does it come and go? \_\_\_\_\_  
What treatment have you already received for you condition? \_\_\_\_\_

## Health History

(Check only those conditions which are applicable)

- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV      | <input type="checkbox"/> Cataracts     | <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> Osteoporosis     | <input type="checkbox"/> Suicide Attempts |
| <input type="checkbox"/> Alcoholism    | <input type="checkbox"/> Chemical D/O  | <input type="checkbox"/> Hernia          | <input type="checkbox"/> Pacemaker        | <input type="checkbox"/> Thyroid Problem  |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Herniated Disc  | <input type="checkbox"/> Parkinson's      | <input type="checkbox"/> Tonsillitis      |
| <input type="checkbox"/> Anemia        | <input type="checkbox"/> Depression    | <input type="checkbox"/> Herpes          | <input type="checkbox"/> Pinched Nerve    | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Anorexia      | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> (H) Cholesterol | <input type="checkbox"/> Pneumonia        | <input type="checkbox"/> Tumors, Growths  |
| <input type="checkbox"/> Appendicitis  | <input type="checkbox"/> Emphysema     | <input type="checkbox"/> Kidney Disease  | <input type="checkbox"/> Polio            | <input type="checkbox"/> Typhoid Fever    |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Liver Disease   | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Fractures     | <input type="checkbox"/> Measles         | <input type="checkbox"/> Prosthesis       | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bleeding D/O  | <input type="checkbox"/> Glaucoma      | <input type="checkbox"/> Migraine H/A    | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Whooping Cough   |
| <input type="checkbox"/> Brest Lump    | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Miscarriage     | <input type="checkbox"/> Rheumatoid Arth. | <input type="checkbox"/> Other: _____     |
| <input type="checkbox"/> Bronchitis    | <input type="checkbox"/> Gonorrhea     | <input type="checkbox"/> Mono            | <input type="checkbox"/> Rheumatic Fever  | _____                                     |
| <input type="checkbox"/> Bulimia       | <input type="checkbox"/> Gout          | <input type="checkbox"/> M. S.           | <input type="checkbox"/> Scarlet Fever    | _____                                     |
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Stroke           | _____                                     |

Dates of Last Exams: \_\_\_\_\_  
Pregnant?  Yes  No    Nursing?  Yes  No    Taking Birth Control Pills?  Yes  No  
List any types of surgeries which you have had and the dates which they occurred:

\_\_\_\_\_

Please list all Medications you are currently taking: \_\_\_\_\_

Allergies: \_\_\_\_\_

## Daily Habits

What type of exercise do you do on a daily basis?  None  Moderate  Heavy  
What do your daily work habits include? ( sitting, standing, light labor, Computer work)

What vitamins do you currently take? \_\_\_\_\_

What kind of other nutritional supplements do you take? \_\_\_\_\_

Do you smoke?  Yes  No    How much per day? \_\_\_\_\_

How much liquor do you consume on a weekly basis? \_\_\_\_\_

How much coffee or caffeinated beverages do you consume on a daily basis? \_\_\_\_\_

**Sports History**

Were you active in sport(s)? Yes No  
Which one(s)? \_\_\_\_\_  
Are you currently active in sports? Yes No  
Which one(s)? \_\_\_\_\_  
Have you been hurt in any of these Sports? Yes No  
When/ How? \_\_\_\_\_

**Chiropractic History**

Have you ever received any form of Chiropractic Care?  Yes  No  
If yes, who was your Chiropractor Practitioner? \_\_\_\_\_ State: \_\_\_\_\_  
If yes, for how long did you receive care? \_\_\_\_\_  
If yes, how often did you go? \_\_\_\_\_  
If yes, when was your last visit? \_\_\_\_\_  
If you stopped, why did you stop? \_\_\_\_\_  
Does anyone in your immediate family receive chiropractic care? Yes No

**Diagnostic History**

**\*\*\* If possible bring your old diagnostic images and report with you when you come in for your apt\*\*\***  
Has anyone ever taken imaging of your injured area? Yes No When? \_\_\_\_\_  
Who has the images now? \_\_\_\_\_  
What is that office’s phone # \_\_\_\_\_

**Have you had, or do you receive any of the following:**  
**(Include..... When, How Often, Last Session)**

Exercise Training: Yes No                      Massage: Yes No  
\_\_\_\_\_  
Yoga: Yes No                                      Acupuncture: Yes No  
\_\_\_\_\_  
Other Modalities: Yes No  
\_\_\_\_\_

**Would you like to subscribe to our Email Newsletter? Yes No**

**For your Convenience we will send Email Appointment Reminders.**

**Authorization Consent**

I Certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during or after the period of chiropractic care, to any third party payers and/or health practitioners. I agree to be responsible for payment of all services rendered at the time of treatment on my behalf or my dependents behalf. I give permission to Dr. Bart Kennedy, D.C., C.C.S.P. to administer chiropractic treatment at Rock Sports and Spine therapy as explained to me, including the benefits and risks involved with the application of chiropractic manipulative therapy and the physical modalities used at this office. I also, agree that the Practice’s Privacy Notice has been provided to me prior to my signing this Consent and that I read and fully understand it.

Sign X \_\_\_\_\_ Date \_\_\_\_\_