Penn Center Chiropractic
3424 William Penn Highway
Suite 168
Pittsburgh, Pa 15235

YOU MUST FILL OUT ALL INFORMATION

Name: _____ Date_____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____Cell_____ Work_____
Email Address: _____
Occupation: _____
Date of Birth: _____ Social Security #: _____
Gender: ☐ Male ☐ Female

Name of Insurance Company: _____
Policy #: _____Group#: _____
Policy Holders Name: _____

List any **Allergies:**
☐Animals ☐Aspirin ☐Bees ☐Chocolate ☐Dairy ☐Dust ☐Eggs ☐Latex ☐Molds ☐Penicillin ☐Ragweed/Pollen ☐Rubber ☐Seasonal Allergies ☐Shellfish ☐Soup ☐Wheat ☐X-Ray Dye
☐Other: _____

List any **Surgeries:**
☐Back ☐Brain ☐Elbow ☐Foot ☐Hip ☐Knee ☐Neck ☐Neurological ☐Shoulder ☐Wrist/Hand
☐Other: _____

List **ALL Past Medical History** conditions:
☐Ankle Pain ☐Arm Pain ☐Arthritis ☐Asthmas ☐Back Pain ☐Broken Bones ☐Cancer ☐Chest Pain ☐Depression ☐Diabetes ☐Dizziness ☐Elbow Pain ☐Epilepsy ☐Eye/ Vision Problems ☐Fainting ☐Fatigue ☐Foot Pain ☐Genetic Spinal Condition ☐Hand Pain ☐Headaches ☐Hearing Problems ☐Hepatitis ☐High Blood Pressure ☐Hip Pain ☐HIV ☐Jaw Pain ☐Joint Stiffness ☐Knee pain ☐Menstrual Pain ☐Mid-Back Pain ☐Minor Heart Problems ☐Multiple Sclerosis ☐Neck Pain ☐Neurologist Problems ☐Pacemaker ☐Parkinson's ☐Polio ☐Prostate Problems ☐Shoulder Pain ☐Significant Weight Change ☐Spinal Cord Injury ☐Sprain/Strain ☐Stroke/Heart Attack
☐Other: _____

List all **Medications** you are currently taking: (Example: Ibuprofen- pain)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you allergic to any medications: ☐ No ☐ Yes List:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List your **Family History:**
☐Arthritis ☐Asthma ☐Back Pain ☐Cancer ☐Depression ☐Diabetes ☐Epilepsy ☐Genetic Spinal Condition ☐High Blood Pressure ☐Heart Problems ☐Multiple Sclerosis ☐Neurological Problems ☐Parkinson's ☐Polio ☐Prostate Problems ☐Stroke/Heart Attack

Please list all family members who had/has any of the problems above:
(Example: Grandmother – High Blood Pressure)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Have you had any auto or other accidents in the past? ☐No ☐Yes
Describe:

_____
_____
_____
_____

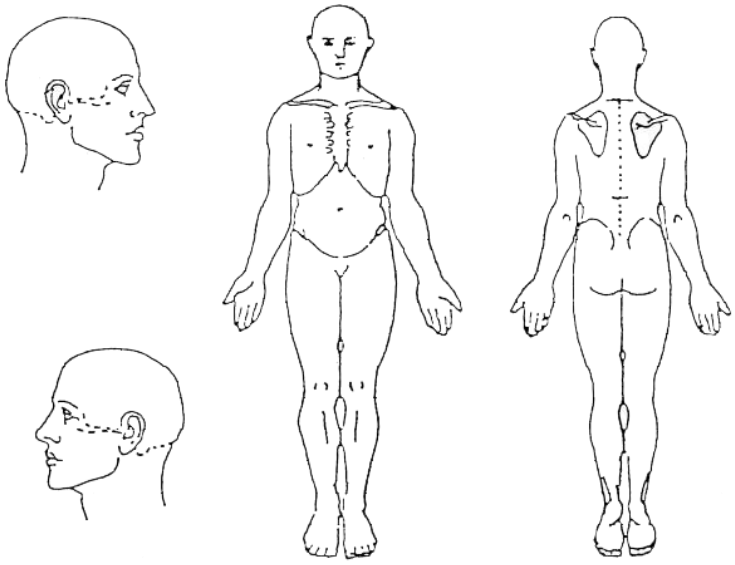
What was date of last physical examination: _____

Do you smoke? ☐No ☐Yes–How many per day? ____
If no were you a former smoker? ☐No ☐Yes
Do you drink alcohol? ☐ No ☐Yes – how many per day? _____
Do you drink caffeine? ☐No ☐Yes – how many per day? _____
Do you exercise? ☐No ☐Yes (what forms and how often):

_____ _____
_____ _____

Have you ever had chiropractic care? ☐Yes ☐No
Where? _____
Why? _____
When was your last visit? _____
Were X-Rays taken? ☐Yes ☐No

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:
□ Become pain free □Explanation of my condition
□Learn how to care for my condition □Resume normal activity level

What is your major complaint? _____
Date problem began? _____
How did this problem begin (falling, lifting, etc.)?
_____
How is your condition changing? □Getting Better □Getting Worse □Not Changing
Have you had this condition in the past? □Yes □No
How often do you experience your symptoms?
□ Constantly (76- 100% of the day) □ Frequently (51-75%)
□ Occasionally (26-50%) □ Intermittently (0-25%)
Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting
□ Tingling □ Radiating Pain □ Tightness □ Stabbing □ Throbbing
□ Other: _____
Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)
□1 □2 □3 □4 □5 □6 □7 □8 □9 □10
How do your symptoms affect your ability to perform daily activities such as working or driving?
(0= no effect and 10=no possible activities) □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
What activities aggravate your condition (working, exercise, etc.)?
_____ _____
_____ _____

What makes your pain better (ice, heat, massage, etc.)?
_____ _____
_____ _____

What is your second complaint? _____
Date problem began? _____
How did this problem begin (falling, lifting, etc.)?
_____
How is your condition changing? □Getting Better □Getting Worse □Not Changing
Have you had this condition in the past? □Yes □No
How often do you experience your symptoms?
□ Constantly (76- 100% of the day) □ Frequently (51-75%)
□ Occasionally (26-50%) □ Intermittently (0-25%)
Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting
□ Tingling □ Radiating Pain □ Tightness □ Stabbing □ Throbbing
□ Other: _____
Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)
□1 □2 □3 □4 □5 □6 □7 □8 □9 □10
How do your symptoms affect your ability to perform daily activities such as working or driving?
(0= no effect and 10=no possible activities) □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
What activities aggravate your condition (working, exercise, etc.)?
_____ _____
_____ _____

What makes your pain better (ice, heat, massage, etc.)?
_____ _____
_____ _____

What is your next complaint? _____
Date problem began? _____
How did this problem begin (falling, lifting, etc.)?
_____
How is your condition changing? ☐Getting Better ☐Getting Worse ☐Not Changing
Have you had this condition in the past? ☐Yes ☐No
How often do you experience your symptoms?
☐ Constantly (76- 100% of the day) ☐ Frequently (51-75%)
☐ Occasionally (26-50%) ☐ Intermittently (0-25%)
Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting
☐ Tingling ☐ Radiating Pain ☐ Tightness ☐ Stabbing ☐ Throbbing
☐ Other: _____
Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
How do your symptoms affect your ability to perform daily activities such as working or driving?
(0= no effect and 10=no possible activities) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
What activities aggravate your condition (working, exercise, etc.)?
_____ _____
_____ _____

What makes your pain better (ice, heat, massage, etc.)?
_____ _____
_____ _____

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

_____ _____
Patient Signature Date

Office Policy

To allow other patients the availability of an appointment, please be advised that if you are to miss an appointment for any reason that you call ahead of time to reschedule. Any patient that fails to cancel an appointment will be charged a $ 5.00 fee.

Thank you for your consideration.

_____ _____
Dr. Succop Patient Signature