

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

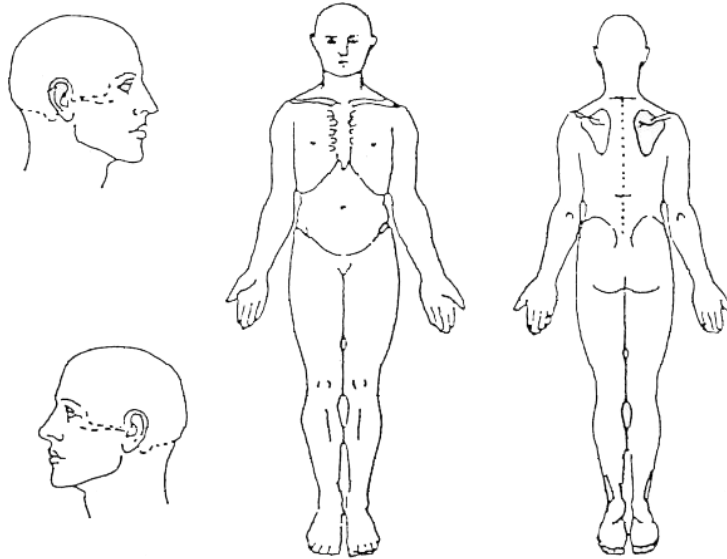
Where? _____

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

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(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