Speigle CHIROPRACTIC

Please fill in all information and PRINT clearly

Name _____ Preferred/Nickname _____ Sex: ☐ M ☐ F

Address _____City _____ State _____ Zip _____

Home phone_____ Cell phone_____

E-mail_____

Social Security # _____ - _____ - _____ Birth date _____ / _____ / _____ Age _____

Employer _____ Occupation _____Work phone_____

Work address _____City _____ State _____ Zip _____

Is it okay to contact you at work? ☐ Yes ☐ No

Status: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Spouse's Name_____ Phone # (s) _____

Children's names and ages: _____

Emergency contact: Name _____Relationship _____ Phone_____

How did you hear about us?

☐ Referral (who?) _____
☐ Website _____
☐ Saw Sign (knew location)
☐ Yellow Pages
☐ Newspaper/Ad
☐ Yelp
☐ Facebook
☐ Yahoo
☐ Google
☐ Google Reviews
☐ Insurance Directory
☐Other _____

What brings you here?

Have you ever had chiropractic care before? ☐ Yes ☐ No

What is the reason for this appointment? _____

Is this appointment related to: ☐ Work ☐ Auto ☐ Sports ☐ Not Applicable Date problem began: _____

Is it getting worse? ☐ Yes ☐ No Is it constant? (✓) ___ Or come and go? (✓) ___

Have you had a similar condition in the past? ☐ Yes ☐ No When? _____

What have you done for this problem? _____

Have you had spinal X-Rays/MRI/CT Scan? ☐ Yes ☐ No Date(s) taken:_____

Health History

What other health problems do you have? _____

_____

Please list any drugs or medications you are taking: _____

_____

Please list any vitamins/herbs/homeopathics you are taking: _____

_____

Have you had any surgeries? Please list:_____

_____

Are you pregnant? ☐ Yes ☐ No If yes, What month? _____

Have you ever been in a work or auto accident? ☐ Yes ☐ No When? _____

♦ Dr. Jamey Speigle ♦ 20397 Route 19N ♦
♦ Landmark II Building ♦ Suite 120 ♦ Cranberry Twp., PA 16066 ♦
♦ P (724) 742-1818 ♦ F (724) 742-1828 ♦ drjamey@speiglechiropractic.com ♦

Health History Continued

Do you smoke? ☐ No ☐ Yes How much? _____ Do you drink alcohol? ☐ No ☐ Yes How much? _____

Do you use illegal drugs? ☐ No ☐ Yes How much?_____ Do you know what an Advanced Directive is? ⬇ **See box below**

> **Advance Directives** are a means for you to tell your health care givers about the care you wish to receive, or not receive, should you ever become unable to tell them of your wishes. There are two forms of advance directives. The first is a Living Will. The other is known as a "Durable Power of Attorney for Health Care Decisions", or may also be called "Durable Appointment of a Surrogate Health Care Decision". Please discuss your Advance Directive choices with your Primary Care Physician.

Have you been diagnosed with cancer? ☐ Yes ☐ No Year:_____ Type:_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

Your Medical Doctor's Name _____ Date of last physical exam: _____

Address _____ City _____ Zip _____ Phone Number _____

If You Have Not Done So Already, Please Give The Receptionist Your Health Insurance Card and Driver's License / Photo ID, So It Can Be Copied. Thank You.

Insurance / Financial Responsibility

Who is responsible for this account? _____

Insured's Name _____ Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other

Insured's birth date **if other than self:** _____ / _____/ _____

Primary Insurance Company _____

ID # _____ Group # _____

Secondary Insurance Company _____

ID # _____ Group # _____

***Notice of Privacy Practices*:** Speigle Chiropractic is required, by law, to maintain the privacy and confidentiality of your protected health information. You have the right to a paper copy of this Notice of Privacy Practices at any time upon request. By way of my signature, I provide Speigle Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient Name (PRINT) _____

Patient Signature _____ Date _____

Any x-rays taken at this office will remain the property of this office. I authorize Speigle Chiropractic to release information to my insurance company for payment. I authorize release of information to Speigle Chiropractic from other facilities regarding treatment. The above statements are true to the best of my knowledge.

Patient Signature _____ Date _____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

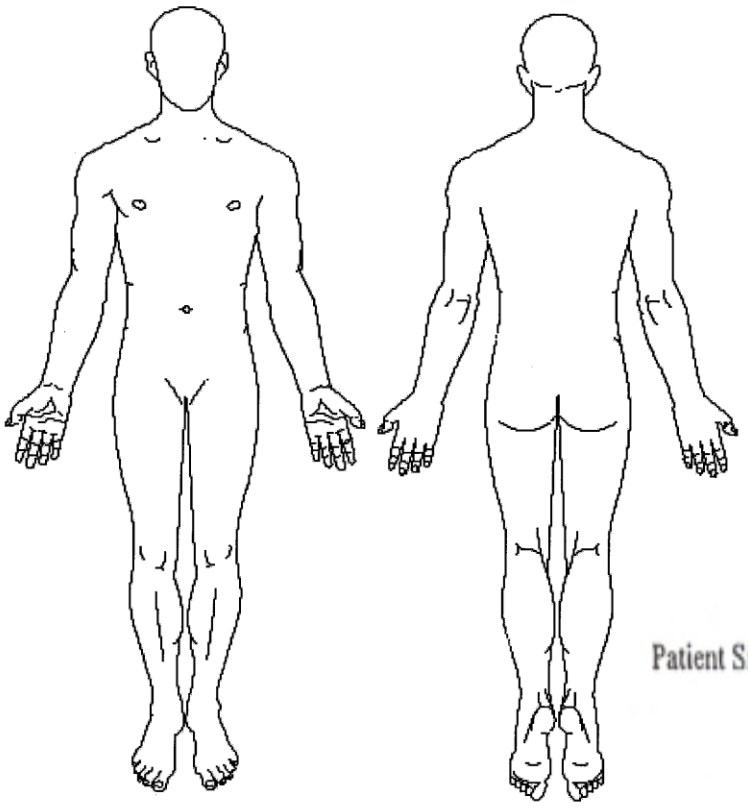
0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Using the letters below, mark the areas on your body where you feel the described sensations. Include all affected areas. Please complete the picture by drawing your face.

A = Ache **B** = Burning **N** = Numbness **P** = Pins & Needles **S** = Stabbing



Patient Signature: _____

Date: _____