

**ABOUT YOU:**

Today's Date: \_\_\_/\_\_\_/\_\_\_ Name: \_\_\_\_\_

How would you like to be addressed by our staff? \_\_\_\_\_

Current Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Permanent Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 (If different from current address)

Home Phone #:(\_\_\_\_)\_\_\_\_-\_\_\_\_ Mobile Phone#:(\_\_\_\_)\_\_\_\_-\_\_\_\_ Daytime Phone#:(\_\_\_\_)\_\_\_\_-\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Referred by: \_\_\_\_\_ Your primary care (medical physician) is: \_\_\_\_\_

Phone # (physician)(\_\_\_\_)\_\_\_\_-\_\_\_\_ May we send a report to him/her about your examination and treatment?  Yes  No

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Hand Dominance:  Right  Left  Ambidextrous

Race:  White/Caucasian  Hispanic/Latino  Black/African American  
 Asian  Hawaiian/Pacific Islander  American Indian/Alaskan Native  
 I prefer not to answer

Ethnicity:  Hispanic  Non-Hispanic  I prefer not to answer

What is your complaint? \_\_\_\_\_

Is your complaint related to a car accident or work injury?  Yes  No If yes, date of injury? \_\_\_\_\_

**PLEASE CHECK EITHER "NONE" OR "YES" IN THE SPACES PROVIDED BELOW:**

Surgeries:  None  Yes – *Please list on blank spaces below with approximate year (if known)*

Surgery	Year Performed	Surgery	Year Performed
<i>Example: Gall bladder removed</i>	1992		

Previous Illness or Diseases (i.e. Cancer):  None  Yes *Please list with approximate year of diagnosis:*

Disease/Disorder	Year Diagnosed	Disease/Disorder	Year Diagnosed
<i>Example. Diabetes</i>	1992		

Name: \_\_\_\_\_

Past/Present Injuries:  None  Yes **Please describe with approximate date** (may include injury for which you are here today)

Injury	Approx. Date	Injury	Approx. Date
<i>Example: Car Accident</i>	1980		

List below any FRACTURES, along with the date/year of the injury:  None  Yes

INJURY	DATE	INJURY	DATE

Past Treatments for **current** condition:  NONE  Chiropractic  Physical Therapy  Medications  Acupuncture  
 Massage  Trigger Point Injections  Epidural Injections  Surgery  Herbal or homeopathic remedies

Family History of Health Problems: Please indicate Paternal (Father's side) or Maternal (Mother's side)

Family Member	Maternal or Paternal	Disease (and date or year of onset)	Deceased?
<i>Example: Grandpa</i>	<i>Maternal</i>	<i>Prostate Cancer-1983</i>	<i>Yes</i>

**Exercise:**

- None  Frequent & Heavy  Occasional  Infrequent  
 Regular  Avoid Due to Pain  Stopped After Therapy  
 Aerobic Activities  Sports Activities

**Work environment:**

- Stressful  Requires Constant sitting  
 Requires constant standing  
 Requires heavy typing or data entry  Requires lifting  
 Phone usage  
 Use headset for phone

**Family Status:**

- Married  Single  Divorced  Widowed  
 Children - How many do you have?: \_\_\_\_\_  
 Are you currently expecting? (Check for yes)

**Substance Usage (check all that apply):**

- Tobacco:  Never  Lives with a former smoker  Former Smoker/Time since quit: \_\_\_\_\_ years  
 Chews-Pouches per week \_\_\_\_\_  Cigarettes-Packs per day \_\_\_\_\_  Cigar-Amount per day \_\_\_\_\_  
 Dips-Cans per week \_\_\_\_\_  Pipe-Pipefuls per day \_\_\_\_\_

Alcohol:  None  Social Drinker  Rarely  Moderately  Lightly  Heavily  Frequently  Recovering alcoholic

**Please check the box/boxes below if you have experienced any of the following:**

QUESTION	YES	QUESTION	YES	QUESTION	YES
Open sore that does not heal		Headaches		ringing in the ears	
Difficulty swallowing		Family history of stroke		Loss of consciousness or momentary black	
Nagging hoarseness		Pain wakes me from a deep sleep		Temporary loss of understanding	
Vertigo, dizziness or lightheadedness		Loss of bladder or bowel control		Problems with balance, gait or coordination	
Night Sweats		Loss of weight without trying		Sensation problems – i.e. numbness	
Coughing up blood or noticing it in your stools		Weakness or strength loss		Problems or changes in vision	

**Current Medications:**  None *Please List (include dosage per day):* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:**  None *Please List:* \_\_\_\_\_  
\_\_\_\_\_

**Vaccinations:**  Received no immunizations/vaccinations  Received typical childhood immunizations  Unknown  
**If Over 65:** Did you have a Pneumonia Shot? Date: \_\_\_\_\_

**Women over 40:** When was your last mammogram? Date: \_\_\_\_\_

**DOCTOR NOTES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status. Medications and allergies will be noted in my records based on the information I have provided and specific brands or dosages will be estimated if not given. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also understand that no guarantee or assurance has been made as to the results that may be obtained.

**Signature of Patient (parent/guardian if minor)** \_\_\_\_\_ **Date** \_\_\_/\_\_\_/\_\_\_

**Print Name** \_\_\_\_\_  Keyed Initials \_\_\_\_\_

*How would you like to receive your appointment reminders?*

- Text (Mobile Service Provider:  AT&T  Cricket  Sprint  T-Mobile  US Cellular  Verizon  Virgin Mobile)
- E-mail Address \* \_\_\_\_\_
- Phone Call
  - Home
  - Mobile
  - Daytime

\* If you supply us with your email address, you will receive an email notification of a care document being available to you. A care document includes some basic information from your exam. The email will include directions on how to access the document. If you would like a unique PIN number, please inform our front desk staff. If you do not want to receive these emails, please choose a method other than emails for your appointment reminders.

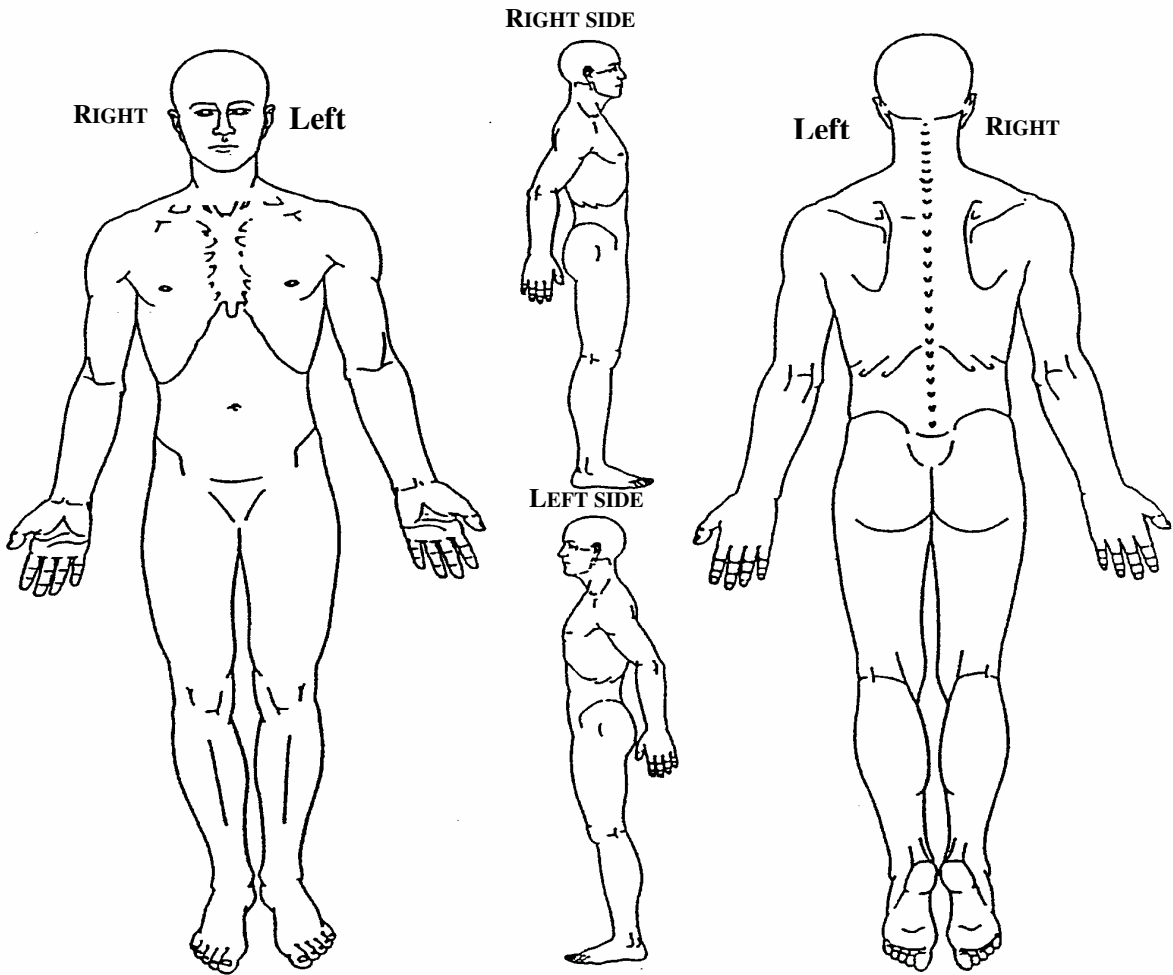


Patient Name \_\_\_\_\_

**Instructions:** Use the symbols in the “key” below to indicate the type and location of the discomfort AS IT FEELS TODAY. Place the letters on the part of the body that you feel the discomfort.

**KEY**

<b>A = ACHE</b>	<b>B = BURNING</b>	<b>C = STABBING</b>
<b>N = NUMBING</b>	<b>P = PINS &amp; NEEDLES</b>	<b>O = OTHER</b>
<b>S = SORE</b>	<b>T = TIGHT</b>	<b>ST = STIFF</b>



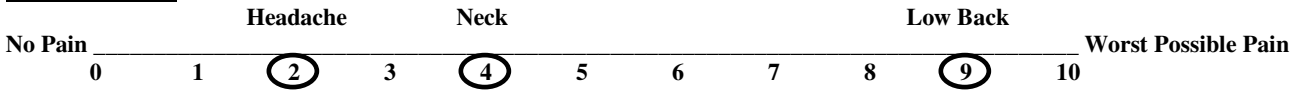
Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_

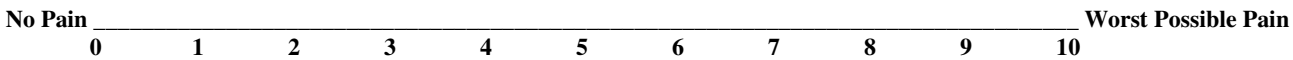
**INSTRUCTIONS:** Please circle the number that best describes the question being asked. Please indicate your pain level right now, average pain, and pain at its best and worst.

**NOTE:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint.

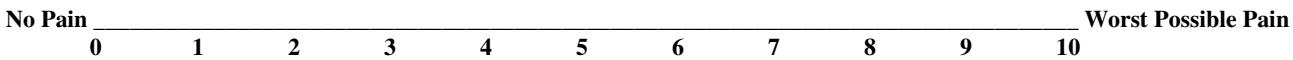
**EXAMPLE:**



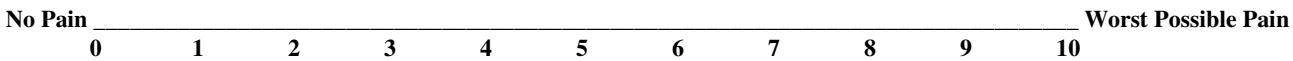
**1 – What is your pain RIGHT NOW?**



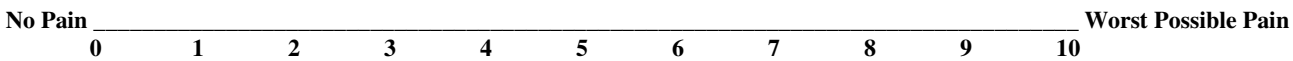
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best?)?**



**4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst?)?**



**OTHER COMMENTS:**

\_\_\_\_\_

Patient signature \_\_\_\_\_

Date \_\_\_\_\_

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## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

I have received a copy of the Russeau Team Healthcare, Ltd. Notice of Privacy Practices. I understand that Russeau Team Healthcare, Ltd. has the right to change its Notice of Privacy Practices from time to time and that I may contact Russeau Team Healthcare, Ltd. at any time to obtain a current copy of the Notice of Privacy Practices.

Please list any persons with whom we MAY share details about your healthcare, or check the box below.

I do not want my records shared with anyone else.

Name	Relationship

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice to Russeau Team Healthcare, Ltd. I also understand that I will not be able to revoke this consent in cases where Russeau Team Healthcare, Ltd has already relied on it to use or disclose my health information. Written revocation of consent must be sent to Russeau Team Healthcare, Ltd.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Legal Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_