Apollo Chiropractic Clinic

Dr. Scott Weinel

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Apollo , PA 15613
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Date____-____-2019 Name____ SS#____-____-______
Home Address__________________________ City___________ State____ Zip_______ Phone (___) ____-_______
Age____ Birth Date___-___-______Weight_____lbs Height_______ft. Marital Status(S,M,D,W) #of Children____
Spouse's Name___________ Are you Pregnant?(Y/N) If a child, Parent's name accompanying ___________________
Emergency contact name ____________________________ relationship _____________ phone (___)____-_______
Employer_________________ Work Address_______________________City__________State____Zip _________
Work Phone #(___)____-______ Occupation Title___________________________ Do You Lift Heavy?(Y?N)
How much do you Lift?_____lbs. How Often?____times/day Describe your work activity ______________________
____
What Insurance will be covering your services received? ____________________________
We will verify your coverage and share that information with you.

*(***Circle below when appropriate-draw a line thru what is not related***)*

What is your Primary Complaint?______________________________ When did it start?___-___-______
Is it related to an Auto, Home, or Work Accident? (Y/N)
If the pain scale is 1-10; 10 = worst, this pain rates a ____ presently. It rated what at the start?____ Did it peak? (Y/N)
Has the pain intensity got better, worse, not changed since starting? Pain character changed or added? Y/N __________
How did it start?____
The primary complaint is: Constant, Reoccurring, or Intermittant? Is the pain localized or moves?
Is it sharp, dull, achy, throbs, burns, numb, tingly, shooting, or other _________ Does pain extend into limbs? (Y/N)
Since onset or started later? ____________Which limb and how far?____
Is it worse in the morning, afternoon, evening, nighttime, or after a certain activity?___________________________
What else makes it worse?____
It is better when you…____
Have you ever had this condition before? (Y/N) Was it treated then? (Y/N) Was it same, worse, less than presently?
Since onset, has it affected you doing anything (list any activities, ie. Sleep, sit, stand, walk, run, task at home or work)
because of this problem?____
____
Have you tried Ice, Heat, Medications (OTC/prescribed)? (Y/N) List any Medications __________________________
____
Have You consulted another Doctor for this complaint?(Y/N) Who?__________________ When?____-____-______
What was their Diagnosis and Treatment?____
Who is your PCP?____________________ Last seen?____-_____-______
Have there been prior Surgeries in this area?(Y/N) When____
Have You Had Any Significant Injuries (auto, work, falls, or other)? (Y/N) Explain _____________________________
____
Have you received any X-rays, MRI, CT scans for this region of body? (Y/N) Where done? _____________________
Have You Received Chiropractic Treatment before? (Y/N) For What?______________ By Whom? _______________
List any Allergies:___________________________ Any Diseases Run in Family?_____________________________

Circle any Which Pertain to You: Arthritis Asthma Cancer Diabetes Dizziness Emphysema Epilepsy
Frequent Headaches Migraines Heart Disease Heart Attack Herniated Disc Kidney Disease
Liver Disease Miscarriage Osteoporosis Pace Maker Rheumatic Fever Stroke Spinal Curvature Thyroid Problems

Are You looking to (circle) Fix this Problem or Patch it Temporarily?

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand if I suspend or terminate my care, all fees for services rendered to me will be immediately due and payable. If Insured, I authorize insurance payments to go to Dr. Weinel.

Signature______________________________ Date ____-____-_____

STW 1-2018 Ins Verified (Y/N)

Please Turn Over

Patient Name ______________________________ date ___-___-_____

Do you regularly Exercise (daily, 3 times, heavily) per a given week? Y/N
How many 8 oz. Glasses of Water do you drink per day? ____
Do you Nutritionally Supplement? Y/N What Supplements do You take? ___________________________________

Do you smoke? Y/N How long have you smoked? ________ How many cigarettes per day? _____

Do you drink alcohol? Beer/liquor? _______________ How much per Event # (shots/12oz. cans)? ________
How many events per Week?_____ per Month? ________

How were You aware of Our Office? Referred by: Internet, Phone Book, Employer's Insurance Provider List, Dr. _____________, Friend/Prior Patient __________________________, Placemat Ad, Drive-by office, Had CDL Exam done Here.

Circle on the figure below, front and/or backside view the area where your symptoms/pain are. Also indicate with a line outwards from area on figure what character(s) you are feeling in that given circled area

sharpness d dullness @ achy th throbbing X burning
/ stabbing * numbness 0 pins and needles