

Welcome To Bluegrass Chiro of Albany

Dr. Susan Dixson, D.C.

Date: _____

Patient information

Patient's Name: _____

Address: _____

City: _____

State: _____ Zip _____

Home Phone: _____

Cell Phone: _____

I give Bluegrass Chiro (,Dr. Susan Dixson, D.C.) Permission to contact me at the above numbers as well as leave a message if needed.

X _____
Signature

Email Address: _____

___ Check if you would like opt OUT of the text reminders

Gender: ___M ___F Age _____ Birth Date: _____

Patient SS# _____

Occupation _____

Employer: _____

Spouse's Name: _____

Spouse's Birth Date: _____

SS#: _____

Spouse's Occupation: _____

How did you hear about us? ___ yellow pages ___ Internet

___ Person _____

___ Other _____

Who is responsible for this account? _____

Relationship to patient? _____

Insurance: _____

Policy Holder Name? _____

In Case of Emergency, Contact:

Name: _____

Relationship: _____

Contact Number: _____

Patient Condition

Reason for visit _____

Is your condition due to an accident? ___ Yes ___ No

Type of Accident: ___ Auto ___ Work ___ Home

Date pain began: _____

Is the condition getting: ___ Better ___ Worse ___ Staying the Same

Circle the number below showing how bad your pain is:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (I'd rather be dead)

Type of pain: (circle) Sharp Dull Achy Throbbing Burning

Shooting Numbness Tingling Cramping Stiffness Stabbing

___ Other : _____

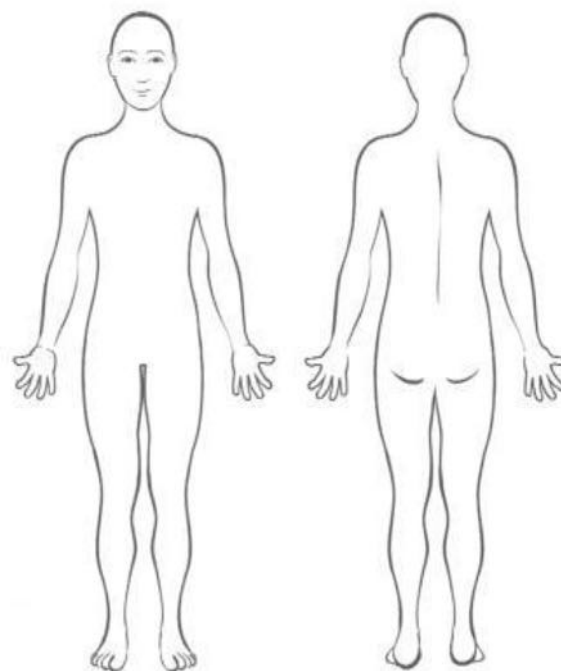
The Pain is: Constant or Comes and Goes

It is difficult to: Sit Stand Walk Bend Lay Down Drive Climb Stairs

My Pain Interferes with: Sleep Work Daily Activities Recreation

I feel better when I: Sit Stand Walk Lie down rest

Use Heat Use Ice Take Advil/Aleve/Ibuprofen/Pain Meds



Mark X on the picture where you have pain numbness or tingling.

Health History

What treatment have you already received for this condition? ___ Medication ___ Surgery ___ Physical Therapy
 ___ Chiropractic Services ___ None ___ Other _____

Name and address of other Doctors that have treated you for this condition _____

Date of last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT Scan, Bone Scan _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors/growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disc	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid		Other _____	
Chemical				Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

Exercise

___ None
 ___ Moderate
 ___ Daily
 ___ Heavy

Work Activity

___ Sitting
 ___ Standing
 ___ Light Labor
 ___ Heavy Labor

Habits

___ Smoking Packs/Day _____
 ___ Alcohol Drinks/Week _____
 ___ Coffee/Caffeine Cups/Day _____
 ___ High Stress Reason _____

Are you pregnant? ___ Yes ___ No Due Date: _____

Family Medical History: ___ Cardiac conditions ___ Diabetes ___ Cancer ___ Arthritis ___ Other _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone _____	_____	_____