Welcome to Summit Regenerative Health!

All information is strictly confidential

Patient name _____ DOB: _____

Sex: M ____☐____ F ____☐____ Other _____

Address/City/Zip Code _____

Phone : _____ Email _____

Insurance _____

Subscriber ID _____ Group # _____

***Please give the front desk your ID and insurance card – FYI payments are due at check out each visit. It is the patient's responsibility to know your own insurance coverage. IF YOU HAVE BLUE CARE NETWORK- you must get a referral from your PCP first, in order to be seen.*

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Patients PCP/ General Physician name and Phone _____

Emergency Contact name and Phone _____

Patient Occupation_____

Current Physical Complaint that brings you in today: _____

_____

Is this physical complaint due to a personal injury? ____☐____ Work Injury? ____☐____ Auto?____☐____

Date of Injury? _____ If Work or Auto injury who is your Claim Adjuster or Attorney/Adjuster name and phone: _____

Date: _____

Signature of Patient: _____

Who referred you so we can thank them ☺ _____

Medical History:

Have you been treated for any medical conditions in the last 12 months? If yes, what?

_____

Date of last exam by your PCP? _____ Previous Chiropractor? _____

Have you had any radiology done in the last 12 months? What? _____

Location of radiology/x-rays _____ Date? _____

Have you had surgery? Date of surgeries? _____

What medications are you taking including vitamins? _____

_____

What medical conditions have you been diagnosed with? _____

_____

PAIN:

Why are you being seen today? _____

Where is your pain located_____ scale of 1 (low) – 10 (extreme) _____

Does your pain wake you up while sleeping? _____

Do you wear orthotics? _____ use a brace?_____ Cane/walker _____

What activities aggravate your pain_____

What eases your pain_____

Do you have any health concerns that may hinder your treatment today? _____

if you, what is it? _____

In order to be seen, diagnosed and treated today, the doctor will require x-rays be completed in office today, so he may treat you accordingly, do you consent? _____

Date: _____ Signature _____

Patient AND Family History – present and past:

Heart conditions? If yes, who? _____ Cancer, if yes, who? _____

Diabetes? If yes, who? _____ Arthritis, if yes, who? _____

If you are a diabetic- what medication do you take _____

If you have a medical diagnosis not listed, please list here and medication if any, you take for it:

_____

Other medical issues or concerns you feel the doctor should know? _____

_____

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Are you a current smoker? _____ If yes, how many/much per day? _____

If you quit, what was the quit date? _____ Drink Alcohol? How much daily? _____

Opioids/ Pain relievers? If yes, what are you prescribed? _____

Caffeine, if yes, what and how much per day? _____

How often do you exercise? If you exercise, what is your daily routine? _____

_____

Please use this area to document any other history or concerns you may have:

I, the Patient, (or representative for patient) state I have filled out this confidential medical information to the best of my knowledge and ability.

Date: _____ Signature _____