REGIONAL CHIROPRACTIC CENTER
LAKE NORMAN
736 Brawley School Road • Suite E • Mooresville, NC 28117
Office: 704-664-1031 • Fax: 704-664-1035 • www.regionalcc.com

PATIENT INFORMATION / HEALTH HISTORY

Full Name: _____ Marital Status (circle one): Single / Mar / Div / Sep / Wid

DOB: _____ Age: _____ Sex: (circle one): Male / Female

Nick Name: _____ Children's Names: _____ Spouse Name: _____

Street Address: _____ City/State _____ Zip: _____

Home Number: _____ Work Number: _____Mobile Number: _____

Social Security Number: _____ Occupation: _____ Employer: _____

How did you hear about us? _____ Other family members seen here? _____

Previous Chiropractic Physician: _____ Date of last visit: _____ Reason for care: _____

Current Medical Physician: _____ Date of last visit: _____ Doctor Phone No. _____

Email Address_____ Text Reminders? YES / NO Cell Provider: _____

HEALTH HISTORY **(PLEASE COMPLETE ALL SECTIONS)**

Primary Complaint: _____ Secondary: _____ When did it start? #1 _____ #2 _____

It began: Suddenly Gradually Is this condition becoming worse? Y N Have you had this condition before? Y N

This condition interferes with (circle all that applies): Work Sleep Daily Activities Driving Other: _____

On a scale 1-10 (1being best and 10 being worst) How severe is it? _____ When did condition start? _____

What caused the condition?_____ What makes it worse? _____ Better? _____

Were other Doctors seen for this condition? Y N If yes, state who: _____ Results? _____

Have you had **ANY** previous accidents (auto, motorcycle, sports, slip/fall) at home or work (**Include all dates**)? _____

_____

Have you ever been knocked unconscious? Y N Do you frequently experience dizziness or lightheadedness? Y N

Have you had **ANY** broken bones or fractures? _____

List ANY surgeries that you have had (Include dates if possible): _____

How would you characterize your health? Good Moderate Poor Do you have a pacemaker or defibrillator implant? Y N

Do you use any of the following?(Please Circle) Tobacco Alcohol Caffeine Dairy Rate the stress in your life: Mild Moderate Extreme

How often do you exercise? Never Occasionally Weekly Daily What type of exercise? _____

Please list Past Prescriptions: _____

Please list Present Prescriptions:_____

Please list any Over-The-Counter Medications: _____

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Please circle **ANY** of the following conditions that you have or have had in the past three months:

Headaches	Ringing in Ears	Stroke/Paralysis	Menstrual Pain
Shooting Head Pain	Chest Pain	Heart Attack	Menstrual Irregularity
Sinus Difficulty	Incontinence	Low Blood Pressure	Diabetes
Loss of Smell	Blurred Vision	High Blood Pressure	Depression
Allergies	Light Sensitivity	Anemia	Irritability
Hay Fever	Shortness of Breath	Seizures	Indigestion
Muscle Spasm Low Back	Asthma	Painful Joints	Cold Feet
Muscle Spasm Neck	Nervousness	Pins/Needles in Legs	Cold Hands
Loss of Taste	Shoulder Pain	Pins/Needles in Arms	Hernia
Inflammation of Throat	Swollen Ankles	Pins/Needles in Hands	Tonsillitis
Thyroid Trouble	Prostate Trouble	Numbness in Legs/Feet	TMJ Pain
Facial Twitching	Kidney Trouble	Numbness in Arm/Hands	Ulcers
Fatigue	Loss of Coordination	Mid Back Pain	Earache
Difficulty Sleeping	Cancer	Low Back Pain	Constipation
Dizziness	Painful Joints	Neck Pain	Rheumatoid Arthritis
Fainting	Osteoarthritis	Hip Pain	MRI Referral
Loss of Balance	Swollen Joints	Facial Pain	Pacemaker

FINANACIAL INFORMATION

Who is responsible for this account? _____ Contact Number: _____

What method of payment will you be using? Insurance Cash Check Credit Card Other

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SIGNATURE ON FILE

I authorize the use of this form on all insurance submissions. Date: _____

- ○ I authorize the release of information to all of my insurance companies
- ○ I authorize that I am responsible for bill
- ○ I authorize payment direct to the treating doctor

Name (print): _____

I permit a copy of this authorization to be used in place of the original Signature: _____

NOTE: We will process your insurance claim as per the healthcare guidelines. If there is a remaining balance not paid, according to our insurance fee schedule, you will be billed for the remaining balance.

Doctors Signature: _____