QUIGLEY
CHIROPRACTIC
8215 Shelbyville Road • Louisville, KY 40222
Phone (502) 412-4915 • Fax (502) 412-4917

PATIENT INFORMATION

Name: _____ **S.S. #:** _____ **Birth Date:** _____

Address: _____ **City:**_____ **State:** _____ **Zip:** _____

Home Phone: (_____)_____ **Cell:** (_____)_____ **Work:** (_____)_____

Email address: _____ **Sex:** F M **Marital Status:** S M D W **No. of Children:** ____

Occupation:_____ **Employer:**_____ **Referred By:** _____

Insured's Name:_____ **Phone:** _____ **Insured's Birth Date:** _____

Insurance Company: _____ **ID/Claim No:** _____

Past Chiropractic Care: Yes No **When?** _____ **Results:** _____

Reason for Today's Visit / Major Complaints:

Type of Pain	Duration of Pain	Intensity of Pain 0 (no pain) – 10 (worst pain)

Symptoms Developed From: Job-Related Injury Auto Accident Other Injury: _____
Unknown Cause Gradual Onset

What activities or treatments make you feel better? _____

What activities or treatments make you feel worse? _____

Is your condition: Improving Worsening Staying the Same?

Is your pain: Constant Comes and Goes?

Describe the quality of your pain: Sharp / Dull / Aching / Burning / Other: _____

Does the pain radiate (travel) to any other areas? N Y **Where?** _____

What time of day is your pain worse? Morning / Afternoon / Evening / Night / Same all day long?

Please list immediate family members having any serious illness or disease:

_____

List any broken bones, fractures or dislocations: _____

Have you ever had any surgeries? N Y **If yes, when and what type?** _____

Have you ever had spinal X-rays taken? N Y **If yes, when?** _____

Do you suffer from any condition other than that for which you are now consulting us? _____

What medications are you presently taking? _____

Do you use tobacco products? N Y **If yes, how many per day?** _____ **per week?** _____

Do you drink alcohol? N Y **If yes how many drinks per day?**_____ **per week?**_____

Do you take recreational drugs? N Y **List:** _____

Do you exercise regularly? N Y **Explain:** _____

It is important for the doctor to know of your past history. Please check all that apply to your past medical history.

General Symptoms
- ❑ Allergies
- ❑ Bronchitis
- ❑ Chills
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Fever
- ❑ Headache
- ❑ Loss of sleep
- ❑ Loss/ Gain of weight
- ❑ Nervousness
- ❑ Neuralgia
- ❑ Night Sweats
- ❑ Numbness or pain in arms/legs/hands
- ❑ Wheezing

Gastro-Intestinal
- ❑ Belching or Gas
- ❑ Colon trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive hunger/thirst
- ❑Gall bladder trouble
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Liver trouble
- ❑ Nausea
- ❑Pain over stomach
- ❑Poor Appetite
- ❑ Poor Digestion
- ❑Vomiting
- ❑Vomiting blood

Eye/Ear/Nose/Throat
- ❑ Asthma
- ❑ Crossed eyes
- ❑ Deafness
- ❑Earache
- ❑ Ear discharge
- ❑ Enlarged thyroid
- ❑ Frequent colds
- ❑ Hay fever
- ❑ Hoarseness
- ❑ Nasal Obstruction
- ❑ Nose bleeds
- ❑ Pain in eyes
- ❑ Poor vision
- ❑ Sinusitis
- ❑ Sore throats
- ❑Tonsillitis

Genito-Urinary
- ❑ Bed wetting
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Unable to control urine
- ❑ Kidney infection
- ❑ Painful urination
- ❑ Prostate trouble

Respiratory
- ❑ Chest pain
- ❑ Chronic cough
- ❑ Difficulty breathing
- ❑ Spitting blood
- ❑ Spitting phlegm

Cardio-Vascular
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Pain over heart
- ❑ Poor circulation
- ❑ Previous heart trouble
- ❑ Rapid heart
- ❑ Slow heart
- ❑ Strokes
- ❑ Swelling ankles
- ❑ Varicose veins

Skin or Allergies
- ❑ Boils
- ❑ Bruising easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or allergy
- ❑ Itching
- ❑ Sensitive skin
- ❑ Skin eruptions

For Women Only
- ❑ Cramps or backaches
- ❑ Excessive flow
- ❑ Hot flashes
- ❑ Irregular cycle
- ❑ Miscarriage
- ❑ Painful periods
- ❑ Pregnant at this time

AUTHORIZATION AND RELEASE:

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I understand and agree to allow this chiropractic office to use my Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's/Guardian's Signature: _____ Date: _____