Sandez Family Chiropractic & Wellness Center, PLLC
1616 Evans Road, Suite 150, Cary, NC 27513
919-535-3091

PATIENT INTRODUCTION FORM

Name (Mr., Mrs., Ms) _____Date _____

Street Address_____ Home Phone_____

City_____ State_____ Zip_____ Cell Phone _____

Social Security No. _____ Driver's License _____

Age_____ Date of Birth_____/_____/_____ Married_____ Single_____ Other_____

Email Address: _____

Occupation_____ Employer_____

Office Address, City, State_____ Phone (office) _____

Primary Care Physician_____ Phone_____

Name of Insurance _____

Policyholder's Name_____ Policyholder's Phone#____ _____

Policyholder's Address_____

Policyholder's Employer_____ Policyholder's birthdate____/____/____

Previous Chiropractic Care: Yes_____ No_____ Doctor's Name_____

Current Symptom(s) _____

Nearest Relative or friend who may be called in case of emergency_____

Relationship to Patient_____ Phone # _____

Who (or what source) referred you? _____

Scheduling Appointments

Sandez Family Chiropractic & Wellness Center, PLLC understands that sometimes circumstances prevent our patients from keeping their scheduled appointments. If you cannot keep your regularly scheduled appointment **please notify our office 24 hours in advance** so that others in need can take the appointment slot. If you are running more than 10 minutes late for your scheduled appointment, please notify our office. **For No Show Appointments (an appointment that you do not show up for, nor call the office to cancel or reschedule), you will forfeit that visit and be charged for that date of service.** Thank you.

Patient Signature: _____ Date: _____

Patient Name_____

PLEASE ANSWER ALL QUESTIONS COMPLETELY OR MARK N/A IF NOT APPLICABLE

Describe the reason(s) for your visit: (Complaints/Symptoms/Pains) _____

_____

What is your PRIMARY Complaint Area? _____

When did your symptoms begin? ____/____/____ OR Are you here for Wellness/Preventative Care? ( )Yes ( )No

Have you ever had this same or a similar condition in the past? ( )Yes ( )No

Describe your symptom(s): (CIRCLE) sharp achy dull deep stinging burning numb tingling stiffness stabbing cramping

Does the pain radiate (travel) to any other part of your body? ( )Yes ( ) NO If so, Where? _____

FEMALES: Is there any chance you could be pregnant? ( )Yes ( )No _____ Unsure

Which word best describes the frequency of your symptoms? (select one)

_____ Constant (75% to 100% of awake time)
_____ Frequent (51% to 75% of awake time)
_____ Intermittent (26% to 50% of awake time)
_____ Occasional (0% to 25% of awake time)

Which phrases best describe changes in your symptoms during the day?

_____ Worse in the morning
_____ Worse in the afternoon
_____ Worse at night
_____ Changes with the weather
_____ Same throughout the day

What helps relieve your symptoms temporarily?

_____ Ice _____ Heat _____ Medication _____ Nothing Helps _____ Other _____

What activities are limited by your symptoms?

_____ Bending	_____ Pushing/Pulling	_____ Lying Down
_____ Bowel Movements	_____ Reading	_____ Getting Dressed
_____ Coughing	_____ Sitting	_____ Urination
_____ Daily Routine	_____ Sleeping	_____ Walking
_____ Driving	_____ Sneezing	_____ Working
_____ Getting Up	_____ Standing	_____Other (Please List) _____
_____ Lifting	_____Turning my Head	_____Exercise/Physical Activity

What date was your most recent:

Physical Exam: _____/_____/_____ Spinal X-ray:_____/_____/_____ MRI/CT Scan: _____/_____/_____

Have you tried other medical treatments for your condition? ( )Yes ( ) No

Type of Treatment? ____ Hospital/Urgent Care ____ Chiropractor or Other Dr. ____ Massage or PT ____ Other

Enter approximate date of your prior treatment: _____/_____/_____ Facility's Phone Number: _____

Name of Doctor/Health Professional & Facility: _____

Patient Name: _____

Are your symptoms the result of an accident (Recent or Years Ago)? ( )Yes ( )No

Have you had any previous accidents/falls/trauma's (i.e. difficult birth, bad falls, car accidents, work/sports injuries?)

_____

_____

Briefly describe your occupational duties: _____

Have you ever fractured a bone? ( )Yes ( )No If yes, which one and when _____

Please list any current medications you are taking or put "N/A" if None:

_____

_____

List any past surgeries with approximate month and year or put "N/A" if none:

_____

_____

Is there family history of cancer, heart disease, diabetes, hypertension or anything else we should know about? Please list below:

_____

_____

Do you have any allergies? ( )Yes ( ) No , If so to what: _____

Do you smoke? ( )N ( )Y , If yes, how many packs per day _____

Do you drink alcoholic beverages? ( )N ( )Y, If yes, how much per week _____

Do you use drugs? (marijuana, cocaine, crack, etc.) ( )N ( )Y, If yes, explain _____

Our Office is Committed to Meeting Your Health Care Goals. Please tell us below, what type of care you may prefer:

_____ Relief of Symptoms Only (likely temporary, no long-term benefits but a big help for now)

_____ Stabilizing and Fixing the Underlying Cause of My Symptoms (longer lasting benefits & whole-body approach)

_____ Wellness, Maintenance, Preventative Care (staying well overtime - just like regular exercise, healthy eating habits)

We are here for you regardless of your choice, we will do our very best to help meet your goals and exceed expectations!

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODE

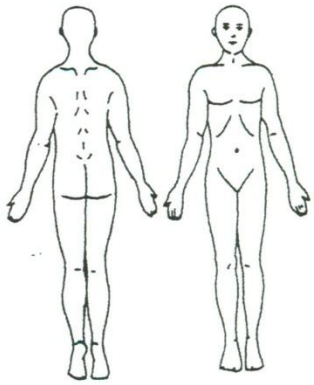
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

FEMALES ONLY:

When was your last period?_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS:

DIAGNOSIS: _____

Patient Name: _____