ZANESVILLE MEDICAL CENTER

1400 Brandywine Boulevard
Zanesville, OH 43701
Phone: 740-450-9000
Fax: 740-450-2494

Date: _____

Last _____ First _____ Middle Initial _____ Birth Date _____ Age _____

Address _____ City _____ ST_____ Zip _____

Phone (H) _____ (C) _____ Email _____

Occupation_____ Employer _____

Spouse's Name _____ D.O.B _____ Spouse Ph _____ Employer _____

Children's Name & Ages _____

Have you had previous Chiropractic care? ☐yes ☐no Have you had Physical Therapy? ☐yes ☐no

Who may we thank for referring you to our office? _____ ☐Walk In ☐Google ☐MD Referral ☐Other_____

Who is your primary care physician? _____ Phone: _____ Date of last physical/exam? _____

May we update your medical doctor regarding your treatment in our office? ☐yes ☐no

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

Current Complaint: _____ Date when symptom first appeared _____

How Did it begin: _____

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare10%

Have you ever experienced the same or similar symptoms? ☐yes ☐no When? _____

Have you been to another doctor for this problem? ☐yes ☐no Who/Where? _____

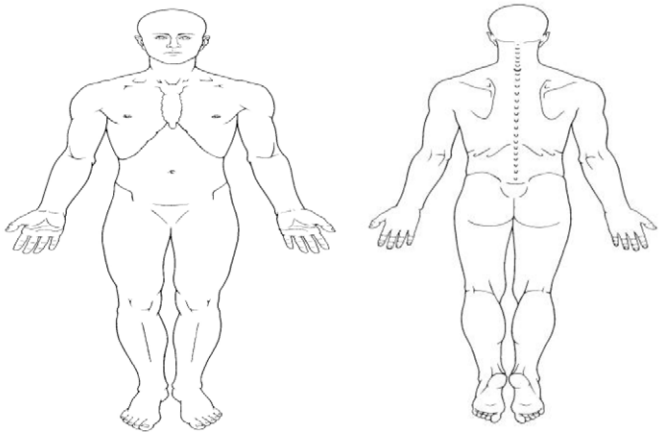
Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Other Do you have Numbness or Tingling? ☐yes ☐no Where? _____

Does the Pain Radiate into: ☐Arm ☐Hand ☐Leg ☐Foot ☐Other _____ ☐Does not radiate

What makes the symptoms increase? _____ What relieves the symptoms? _____

Drugs you now take: ☐Nerve Pills ☐Pain Pills ☐Muscle Relaxer ☐Blood Pressure ☐Other:_____

Do any family members suffer from the same complaint? If so, who?_____



Please mark off all areas of complaint on the diagrams with the following indicators:
AAA=ache DDD=dull NNN = numbness
TTT= tingling BBB= burning SSS=sharp/stabbing
XXX = other

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme)

0 ◊◊◊ 1 ◊◊◊ 2 ◊◊◊ 3 ◊◊◊ 4 ◊◊◊ 5 ◊◊◊ 6 ◊◊◊ 7 ◊◊◊ 8 ◊◊◊ 9 ◊◊◊ 10

Do you have knee pain? If so, please describe: _____

Have you ever been in an auto accident? ☐Past Year ☐Past 5 Years ☐Over 5 Years ☐Never

Please describe: _____

Please list ALL surgeries, injuries, accidents, falls, etc: _____

_____

List all Medications/Vitamins:

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Do you smoke? ☐yes ☐no If yes, how many packs per week?_____**Have you ever smoked in the past?** ☐yes ☐no When did you quit?_____
Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? _____
Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? _____
Do you exercise? ☐yes ☐no If yes, how many times per week and what type? _____
Do you have a high stress level? ☐yes ☐no If yes, list reasons:_____

Is there any possibility that you may be pregnant? ☐yes ☐no **Date of Last Menstrual Cycle** _____

Health History - Please circle all that apply

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M. S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V. D.	Whooping Cough	
Chronic Fatigue	High Blood Pressure		Fibromyalgia	Other_____			

Family History – List any diseases and conditions that are current health problems of family members.

_____

_____

Insurance Information

Is your condition due to an automobile accident? ☐yes ☐no **If yes, Date of Accident:** _____ / _____ / _____

Have you filed an accident report? ☐yes ☐no

Is your condition due to job injury? ☐yes ☐no **If yes, Date of Accident:** _____ / _____ / _____

Have you filed an injury report? ☐yes ☐no

Do you have health insurance? ☐yes ☐no

If yes, what is the company? _____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that **Zanesville Medical Center** will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to **Zanesville Medical Center**. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____