Welcome to the Chiropractic Center of Myrtle Beach

Today's Date ____________________ Account Number ___________________

Legal Name: First ___________________MI ____Last_________________ Suffix _____Nickname______________

Mailing Address ____ Apt__________

City ____ State _________ Zip ___________-________

Date of Birth: _______________________ Age ______ Social Security Number _________-________-________

Marital Status: S M W D Sep Spouse/Parent Name ____

Home phone: _______________________________ Cell phone: ____

E-mail address: ____

Your Occupation __________________________Employer Name ____

Employer Address: ____________________________________City ____________________ST ____ Zip________

Employer Phone: ________________________________Ext______________

Student: Y / N School Name: ____

Primary Insurance Co. Name ____ Through work? / Individual (circle one)

Subscriber ID# ________________________________ Group Name (Employer): __________________________

Group Number: _________________________________

Policyholder Name: _____________________________________ Policyholder DOB_________________________

Policyholder relationship to patient: ___________________________

Secondary Insurance Co. Name _______________________________________ Through work? / Individual (circle one)

Subscriber ID# ________________________________ Group Name: __________________________________

Group Number: _________________________________

Policyholder Name: __________________________ Policyholder DOB_________________________

Policyholder relationship to patient: ___________________________

Have you ever been to another doctor for this problem? Y N Who? ____________________________________

Is this problem due to a recent auto accident? Y N (If yes, please alert receptionist now)

Is this problem due to recent workers compensation? Y N (If yes, please alert receptionist now)

Who referred you to this office? ____

Non Participating Provider – Payment is due at time of service
unless other arrangements have been made.

Please allow office staff to copy your driver's license and any insurance card(s) you may have.

Patient name:___________________________ Account number:___________________

Please circle the problems you are having right now and indicate the pain scale & frequency of the pain.

(least) (most)

Pain Scale: 1 2 3 4 5 6 7 8 9 10

Frequency: 100% - constant, 75% - frequent, 50% - occasional, 25% - intermediate, 10% - rare

	Pain Scale	Frequency		Pain Scale	Frequency
Head	_____	_____	Groin	_____	_____
Ear	_____	_____	Shoulder	_____	_____
Face	_____	_____	Arm	_____	_____
Neck	_____	_____	Forearm	_____	_____
Chest	_____	_____	Hand	_____	_____
Abdomen	_____	_____	Posterior leg (back)	_____	_____
Upper back	_____	_____	Anterior leg (front)	_____	_____
Lower back	_____	_____	Knee	_____	_____
Sacroiliac	_____	_____	Foot	_____	_____
Hip	_____	_____			

Date symptoms started: ____________________(required)

It hurts when I: lift , stand , sit , bend , walk , or:

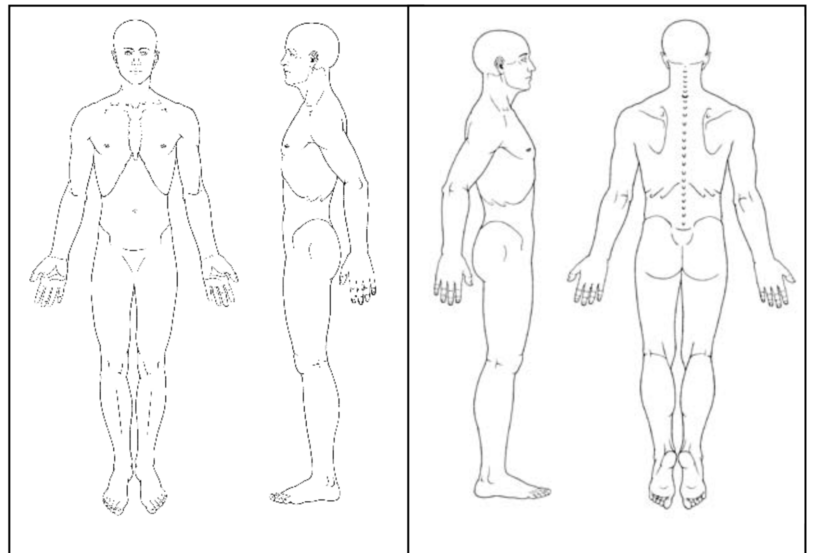
____

Circle any related complaints;

Asthma	Wrist tendonitis
Bronchitis	Carpal tunnel
Chest pain	Leg numbness/tingling
Cold	Leg weakness
Dizziness	Calf pain
Flu	Foot numbness/tingling
Headaches	Wrist pain
Indigestion	Tennis elbow
Lightheadedness	Elbow pain
Nervousness	Finger numbness/tingling
Night Sweats	Arm numbness/tingling
Bloating	Upper back spasm
Burning urination	Lower back spasm
Constipation	Bursitis
Diarrhea	Shoulder stiffness
Tendonitis	Frequent urination

My goal with Chiropractic care is to:_____________

Please Mark Your Area Of Pain Below:



DO NOT WRITE BELOW – FOR PHYSICIAN USE ONLY

Onset:________________________

How: _________________________

Duration:______________________

Reoccurrence: Y N _____________

Radiating Pain Y N _____________

RX:____

____

____

____

☐ Consent to treat on findings

****LUMBAR ORTHOPEDIC**
All + findings must describe location of provoked pain, radiation and intensity on a 1-10 scale

	Location	Radiates to	Intensity
SLR			
Braggards			
Well Leg			
Kemps			
Bechterew			
Valsalva			
Milgrims			
Lidners			

****CERVICAL / THORACIC ORTHOPEDIC**
All + findings must describe location of provoked pain, radiation and intensity on a 1-10 scale

	Location	Radiates to	Intensity
Cerv. Comp			
Max. Comp			
Cerv. Dist.			
Shld. Dep.			
Adsons			
Halsted			
Wrights			
Edens			
Valsalva			

Weight________

Height_________

Patient Name: ______________________________ Account Number: ____________________

Please list all previous treatments for this condition:

Name of Treating Physician ______________________________ Dates of Treatment ________________
Type of Treatment or Drugs Prescribed ____

Name of Treating Physician ______________________________ Dates of Treatment ________________
Type of Treatment or Drugs Prescribed ____

Please list all past surgeries:

Type ______________________________ When _______________ Doctor ____________________
Type ______________________________ When _______________ Doctor ____________________
Type ______________________________ When _______________ Doctor ____________________
Type ______________________________ When _______________ Doctor ____________________

Please list all previous accidents and falls:

What ____ When _____________________
What ____ When _____________________
What ____ When _____________________
What ____ When _____________________

Please list all medications or vitamins you are currently taking:

____
____
____

VASCULAR RISK EVALUATION

*Have you ever suffered a stroke? Y N

*Anyone in your family had a stroke Y N
Who / Age ___________________________________

*Have you ever had a heart attack? Y N

*Anyone in your family had a heart attack Y N
Who / Age ___________________________________

*Do you have a vascular disease? Y N

*Anyone in your family have a vascular dx Y N
Who / Age ___________________________________

*Do you have high blood pressure? Y N

*Anyone in your family have high BP Y N
Who / Age ___________________________________

Do you smoke? Y N How much ________________ How long ______________
Have you ever smoked in the past? Y N When did you quit? _____________________________
Do you take birth control pills? Y N Have you ever taken birth control pills? Y N

PATIENT / RESPONSIBLE PARTY SIGNATURE ______________________________ DATE ______________