PARAGON WELLNESS CENTER

RECLAIM YOUR HEALTH. REVIVE YOUR LIFE.

_____
Patient Number
(Office Use Only)

PLEASE NOTE:

This file must be saved to your desktop before and after completing!

PATIENT INFORMATION

Date _____ First Name _____ Middle Name _____ Last Name _____

SSN _____ Sex _____ Birth Date _____ Height _____ Weight _____

Marital Status _____ Spouse Name _____ Number of Children _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Emergency Contact _____

Emergency Relation _____ Emergency Phone _____

EMPLOYER INFORMATION

Employed? ☐ Yes ☐ No

Employer Name: _____

Occupation: _____

INSURANCE INFORMATION

Primary Insurance Information

Insurance Company Name _____ Plan Name _____

Phone # _____ Primary ID/Policy _____ Primary Group # _____

Policy Holder's Name _____ Policy Holder's DOB _____

If you are NOT the Policy Holder, what is your relation to the Policy Holder? _____

For verification puposes, what is the Policy Holder's Social Security Number? _____

Secondary Insurance Information

Insurance Company Name _____ Plan Name _____

Phone # _____ Secondary ID/Policy _____ Secondary Group # _____

Policy Holder's Name _____ Policy Holder's DOB _____

If you are NOT the Policy Holder, what is your relation to the Policy Holder? _____

For verification puposes, what is the Policy Holder's Social Security Number? _____

REFERRAL INFORMATION

I was referred by _____

_____
Patient Number
(Office Use Only)

How did you hear about the clinic?

☐ Advertisement ☐ Newspaper ☐ Community Event ☐ Provider Talk ☐ Family/Friend ☐ Other _____

REASON FOR VISIT

Describe in your own words why you wanted to come for an appointment today:

PERSONAL HEALTH INFORMATION

Complaints/Concerns

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptom has been present.

Problem	Onset	Frequency	Severity
E.g. Headaches	*June 2007*	*4 times per week*	*Mild / Moderate / Severe*
1.			
2.			
3.			
4.			
5.			
6.			
7.			

When was the last time you felt well? _____

Did something trigger your health changes?

Sleep

Average number of hours you sleep? _____ Do you have trouble falling asleep? ○ Yes ○ No

Do you feel rested upon awakening? ○ Yes ○ No Do you have problems with insomnia? ○ Yes ○ No

Do you snore? ○ Yes ○ No Do you use sleeping aids? ○ Yes ○ No Explain: _____

Condition

_____
Patient Number
(Office Use Only)

Describe your condition: _____

Pain level on scale of 1 - 10 (10 is excruciating pain) At its best? _____ At its worst? _____ Now? _____

Type of injury, if applicable _____

How did it occur? ☐ Work ☐ Automobile ☐ Fall ☐ Other _____

Condition Onset Date _____ Have you missed work related to this condition? ◯ Yes ◯ No

Unable to work from (dates) _____ to _____

Received other treatment for this? ◯ Yes ◯ No When and by whom? _____

X-rays taken? ◯ Yes ◯ No Do you currently receive chiropractic care? ◯ Yes ◯ No

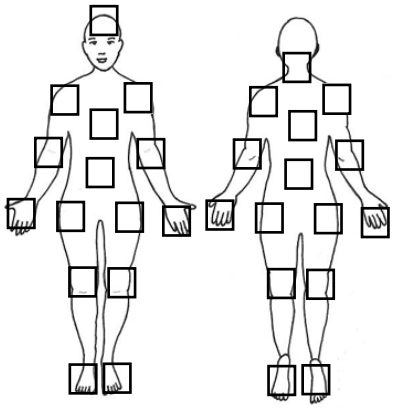
What clinic or chiropractor provides that care? _____

Did you receive chiropractic care in the past? ☐ Yes ☐ No If yes, when and where? _____

Please check the character of your current pain (you may check more than one):

Sharp ☐ Stabbing ☐ Dull ☐ Aching ☐ Soreness ☐ Stiffness ☐ Weakness ☐

Throbbing ☐ Numbness ☐ Shooting ☐ Burning ☐ Tingling ☐



Please rate the degree of you pain between 0-10, 0 being no pain and 10 being unbearable: _____

How often are your symptoms present?

Constant ☐ Frequent ☐ Occasional ☐ Intermittent ☐

Since your problem began, is the pain? Increasing ☐ Decreasing ☐ No Change ☐

What activities make symptoms BETTER? Sitting ☐ Standing ☐ Laying Down ☐

Movement/Exercise ☐ Sleep/Rest ☐ Other(describe) _____

What activities make symptoms WORSE? Sitting ☐ Standing ☐ Coughing/Sneezing ☐

Movement/Exercise ☐ Sleep/Rest ☐ Other(describe) _____

Tobacco/Alcohol

Currently using tobacco? ◯ Yes ◯ No How many years? _____ Packs per day _____

If yes, what type? ☐ Cigarette ☐ Smokeless ☐ Cigar ☐ Pipe ☐ Patch/Gum

Previous smoking? How many years? _____ Packs per day _____ Are you exposed to 2nd hand smoke? ◯ Yes ◯ No

If yes, explain: _____

How many drinks currently per week? (1 drink=5 oz. wine, 12 oz. beer, and/or 1.5 oz. spirits)

☐ None ☐ 1 to 3 ☐ 4 to 6 ☐ 7 to 10 ☐ More than 10

Previous alcohol intake? ◯ Yes ◯ No If yes, was it: ◯ Mild ◯ Moderate ◯ High

Patient Number
(Office Use Only)

Allergies

I am allergic to the following medications:

I am allergic to the following foods or supplements:

Please list your symptoms/reactions to the above medications and/or foods:

Medications and Supplements

Medications: Please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs.

Medication Name	Dosage

Supplements: List all vitamins, minerals, and other nutritional supplements that you are currently taking.

Supplement Name	Dosage

Health History

Patient Number
(Office Use Only)

Have you ever had any of the following:

Illnesses	Yes	No
Chicken Pox	☐	☐
Measles	☐	☐
Mumps	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Chronic Fatigue Syndrome	☐	☐
Crohn's Disease or Ulcerative Colitis	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy, convulsions	☐	☐
Gallstones	☐	☐
Gout	☐	☐
Heart attack/Angina	☐	☐
Heart failure	☐	☐
Hepatitis	☐	☐
High Blood Pressure	☐	☐
Irritable bowel	☐	☐
Kidney stones	☐	☐
Mononucleosis	☐	☐
Pneumonia	☐	☐
Rheumatic fever	☐	☐
Sinusitis	☐	☐
Sleep Apnea	☐	☐
Stroke	☐	☐
Thyroid disease	☐	☐
Other (describe)		

Injuries	Yes	No
Head Injury	☐	☐
Neck Injury	☐	☐
Back Injury	☐	☐
Fracture	☐	☐
Other (describe)		

Diagnostic Studies	Yes	No	Date Performed
Chest X-ray	☐	☐	
Mammogram	☐	☐	
EKG	☐	☐	
Colonoscopy	☐	☐	
Upper GI Series	☐	☐	
Barium Enema	☐	☐	
CAT scan of abdomen	☐	☐	
CAT scan of brain	☐	☐	
CAT scan of spine	☐	☐	
Liver scan	☐	☐	
Bone scan	☐	☐	
Neck X-rays	☐	☐	
Back X-rays	☐	☐	
MRI	☐	☐	
Bone Density Test	☐	☐	
Blood Tests	☐	☐	
Other (describe)			

Operations	Yes	No
Tonsillectomy	☐	☐
Tubes in Ears	☐	☐
Appendectomy	☐	☐
Gall Bladder	☐	☐
Hernia	☐	☐
Hysterectomy	☐	☐
Dental Surgery	☐	☐
Other (describe)		

Hospitalizations	
When	**For What Reason**

Women Specific

_____
Patient Number
(Office Use Only)

Check the box if yes and provide number.

☐ Pregnancies _____ ☐ Miscarriage _____ ☐ Living Children _____ ☐ Abortion _____ ☐ Cesarean _____

☐ Vaginal Delivery _____ ☐ Postpartum Depression _____ ☐ Toxemia _____ ☐ Baby Over 8 Pounds _____

☐ Gestational Diabetes _____ Are you currently pregnant? Yes ☐ No ☐

Menstrual History

Age At 1st Period _____ Menses Frequency _____ Length _____

Painful? ○ Yes ○ No Clotting? ○ Yes ○ No Have you ever missed your period? ○ Yes ○ No

For how long? _____ Are you menopausal? ○ Yes ○ No Age At Menopause _____

Last Menstrual Period _____

Do you take any hormone contraception? ☐ Birth Control Pill ☐ Patch ☐ Nuva Ring

Acknowledgments

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial.

FOR ALL PATIENTS

I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in the practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure and disease or entity.

Initials:_____

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials:_____

I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY) _____

Initials:_____

I grant permission to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials:_____

I acknowledge that any insurance I may have is an agreement between the center and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials:_____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.

Initials:_____

Please email this completed form to **info@paragondrs.com**

By typing or signing your name below on the signature line, you are agreeing to all of the paragraph above.

Signature _____ Date _____

Thank you!