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Referred By ___________________________

PATIENT INFORMATION

Name____Today's Date________________________
Date of Birth__________________ Height____________ Weight____________ Dominant Hand? R L
Address ___________________________________ City_________________________ Zip _____________
Phone (cell) __________________________________Phone (other) ______________________________
Email _______________________________________ DL#____

Health Insurance Company ___________________________ Policy# _______________________________
Address ___________________________________ City ________________________ Zip ______________

If you have Medicare:
Medicare # ___________________________________
Do you have a supplement? If so who: ___________________________________

Please note that payment is due upon services rendered and you are your responsibility. I hereby authorize Fulmore & Associates Chiropractic and Spinal Injury Centers, P.A. to release any information regarding my treatment of injuries/illnesses to insurance company(s) or legal representatives when requested in writing, accompanied by my signature. I understand that I am responsible for any amounts not paid by the insurance company.

_______________________________________ ___________________________
Patient/Guardian Signature Date

Symptoms

Patient ____________________________ Date ____________ Date of Injury ___________

☐ Initial ☐ Update

Please fill in all symptoms you currently have *that you did not have* *before* the accident.

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" Sound with Neck Movements
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain ☐ Left ☐ Right
- ☐ Upper Arm Pain ☐ Left ☐ Right
- ☐ Elbow Pain ☐ Left ☐ Right
- ☐ Forearm Pain ☐ Left ☐ Right
- ☐ Wrist Pain ☐ Left ☐ Right
- ☐ Hand Pain ☐ Left ☐ Right
- ☐ Hip Pain ☐ Left ☐ Right
- ☐ Upper Leg Pain ☐ Left ☐ Right
- ☐ Knee Pain ☐ Left ☐ Right
- ☐ Lower Leg Pain ☐ Left ☐ Right
- ☐ Ankle Pain ☐ Left ☐ Right
- ☐ Foot Pain ☐ Left ☐ Right
- ☐ Jaw Pain
- ☐ Clicking in Jaw
- ☐ Pain when Chewing
- ☐ Face Pain
- ☐ Chest Pain
- ☐ Stomach Pain
- ☐ Bruise to ________________________
- ☐ Scrape/Cut to ____________________
- ☐ Other Symptom __________________
- ☐ Other Symptom __________________

Neurological Symptoms

- ☐ Numbness in Arms or Hands
- ☐ Numbness in Legs or Feet
- ☐ Tingling in Arms or Hands
- ☐ Tingling in Legs or Feet
- ☐ Weakness in Arms or Hands
- ☐ Weakness in Legs or Feet

Brain/Neuropsych/MTBI Symptoms

- ☐ Flashbacks to Accident
- ☐ Impatience
- ☐ Frustration
- ☐ Wanting to be Alone
- ☐ Hearing Problems
- ☐ Change in Sense of Taste
- ☐ Change in Sense of Smell
- ☐ Sleeping Problems
- ☐ Difficulty with Hand Coordination
- ☐ Difficulty Planning or Organizing
- ☐ I am more easily Distracted
- ☐ Social Withdrawl/Feeling isolated
- ☐ Sleepiness
- ☐ Nausea
- ☐ Vomiting
- ☐ Seizure
- ☐ Difficulty Concentrating
- ☐ Day Dreaming
- ☐ Mindless Staring
- ☐ Mood Swings
- ☐ Agitation
- ☐ Sadness
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Disoriented
- ☐ Confused
- ☐ Difficulty Speaking
- ☐ Headache
- ☐ Attention Problems
- ☐ Appetite Change
- ☐ Pupils Different Sizes
- ☐ Dizziness
- ☐ Balance Problems
- ☐ Difficulty Walking
- ☐ Groggy
- ☐ Very Tired
- ☐ Dozing During The Day
- ☐ Personality Change
- ☐ Can't Remember Numbers
- ☐ Reading Problems
- ☐ Writing Problems
- ☐ Difficulty with Adding/Subtracting
- ☐ Poor Attention
- ☐ Difficulty Learning New Things
- ☐ Difficulty Understanding
- ☐ Difficulty Remembering
- ☐ Re-reading Things to Understand It
- ☐ Anger
- ☐ Difficulty Making Decisions
- ☐ Slurred Speech
- ☐ Depression
- ☐ Change in Sexual Functioning
- ☐ Anxiety/Nervousness
- ☐ Reduced Confidence
- ☐ Helplessness
- ☐ Apathy (Don't Care)
- ☐ Irritable

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REVIEW OF SYSTEMS

-Please check all the apply-

GASTRO-INTESTINAL
___Jaundice
___Bladder trouble
___Poor appetite
___Poor Digestion
___Excessive Ulcer
___Belching/Gas
___Nausea
___Vomiting
___Vomiting Blood
___Stomach Discomfort
___Constipation
___Diarrhea
___Colon Trouble
___Hemorrhoids
___Liver Trouble

CARDIOVASCULAR
___Strokes
___Poor circulation
___Heart problems
___High blood pressure
___Swelling of ankles

EAR, EYE, NOSE, THROAT
___Ear problems
___Thyroid trouble
___Poor vision
___Pain in eyes
___Deafness
___Sinus trouble
___Tonsillitis
___Frequent colds
___Asthma
___Hay fever
___Hoarseness
___Nose bleeds
___Sore throat

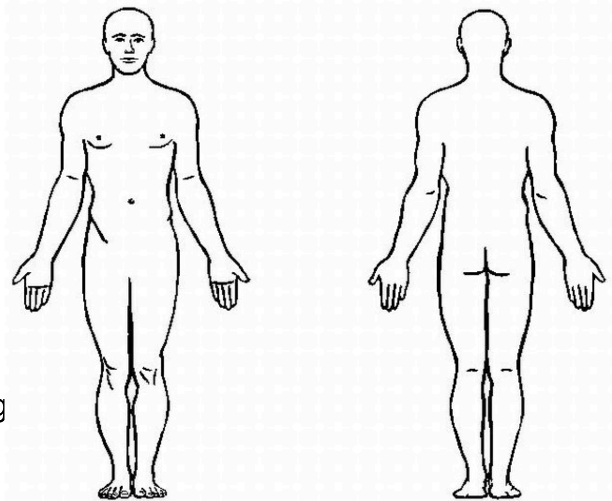
SKIN
___Hives of allergy
___Sensitive skin
___Boils
___Dryness
___Bruising
___Itching
___Skin eruptions

RESPIRATORY
___Chronic cough
___Spitting phlegm
___Chest pain
___Difficulty breathing
___Lung problems

GENITO-URINARY
___Frequent urination
___Painful urination
___Blood in urine
___Kidney infection
___Bladder infection
___Bed wetting
___Inability to control urinating
___Prostate trouble

WOMEN ONLY
___Irregular periods
___Hot flashes
___Cramps/Backaches
___Miscarriage
___Vaginal discharge
___Pregnant now

PLEASE CIRCLE ANY AREAS WHERE YOU FEEL PAIN BELOW



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NOTICE OF PRIVACY PRACTICES
-PATIENT ACKNOWLEDGEMENT-

Patient Name: ____________________________ Date of Birth: ____________________

I have received and understand this practice's NOTICE OF PRIVACY PRACTICES written in plain language. This notice provides in detail the uses and disclosures of my protected health information that may be made by the practice, my individual rights, how I may exercise the rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its NOTICE OF PRIVACY PRACTICES, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised NOTICE OF PRIVACY PRACTICES, upon request.

________________________________ ______________________ _______________

Patient/Guardian Signature | Relationship to patient if a minor | Date

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