



South Windsor Neck & Back, LLC

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Which type(s) of care are you interested in? Check all that apply.

- Pain relief.
- Home exercises.
- Corrective care. I am interested in fixing the cause of my problem, if possible.
- Wellness / Preventive care.
- Second opinion for another treating doctor / insurance company.
- Vestibular rehabilitation for vertigo, motion sickness, fall prevention.
- Sports performance. Improved agility, focus, concentration and accuracy.
- ADD / ADHD biofeedback.
- Electrodiagnostic evaluation: EMG / NCV testing.
- Evaluation for permanent impairment / disability rating.
- Nutrition consultation. If yes, for what issues? _____
- Acupuncture.

I hereby give South Windsor Neck and Back, LLC permission to release my records to my health insurance company and to my other doctors; including psychiatric, substance abuse and AIDS related information. Further, I hereby acknowledge that I have been given access to, and reviewed, a copy of the practice PRIVACY POLICY and I understand that I may contact the office manager if I have any further questions or complaints and that I am entitled to receive a written copy of these policies at my request. I also understand that I am entitled to receive updates upon request if the PRIVACY POLICY is amended or changed in a material way. I understand my insurance company may require a referral for care. If I fail to obtain a valid referral I agree to assume responsibility for payment of my charges. I understand that as a courtesy this office will attempt to verify my insurance benefits, but it is ultimately my responsibility to be aware of covered services, co-pay and deductible amounts unique to my health plan.

PAYMENT IS DUE AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____

REFERRED BY

- Patient Name _____
- Physician Name _____
- Insurance Book
- Phone Book
- Other _____
- FunctionForLife.com
- Insurance website

PRIMARY CARE PHYSICIAN

Dr. _____ Telephone Number _____

Office Address _____

EMERGENCY CONTACT

Name of relative or close friend not living in your home _____

Home Phone _____ Work Phone _____ Cell Phone _____

CHIEF COMPLAINTS

When did it start? _____ Work related? Yes No

How did it happen? _____

What makes it feel better? _____

What makes it feel worse? _____

Please describe the pain (sharp, stiff, etc) _____

What time of day is it best? _____ worst? _____ No timing

How severe is your pain? (0 being no pain, 10 being unbearable) 0 1 2 3 4 5 6 7 8 9 10

What providers have you seen for this condition? MD DC PT _____ Are you still seeing them? Yes No

Prior Examinations

What area of the body?

What hospital/location?

X-ray

MRI

Cat scan

Blood work

Other

Do you have a permanent disability rating? No Yes _____ %

Location _____

What activities have been affected by your condition? _____

The last time you felt good was _____ What are your goals with care? _____

If we were your HEALTH GENIES, what would be your ONE health wish? _____

Please honestly rate your ability, resources and desire to make the necessary commitments and modifications in order to significantly impact the typical course of your current disease or disorder.

Likely only minor changes Likely only moderate changes Likely I can make major changes I can do almost anything it may take

HEALTH CONDITION

Check condition if present

Circle condition if past

GENERAL HEALTH

Asthma

Fatigue

Clotting disorder / blood thinners

Cancer _____

Diabetes

Fever

Loss of bowel or bladder control

Chemotherapy

Hepatitis

Loss of appetite

Severe pain that wakes you from a sound sleep

Radiation

Lyme disease

Night sweats

Steroid medication use > 3 months

HIV

Swollen glands

Unexplained weight loss/gain

MUSCULOSKELETAL

Muscle weakness

Pins/needles

Numbness

Arthritis/Degeneration

Muscle twitching

Headaches

TMJ/Jaw pain

Immune suppression

Muscle cramping

Neck pain

Osteoporosis

Joint pain _____

Arm pain R or L?

Back pain

Compression fracture

Leg pain R or L?

Shoulder pain

Rheumatoid arthritis

NEUROLOGIC

Decreased sense of smell

Hearing problems

Incoordination

Clumsiness

Blurred vision

Difficulty speaking

Motion sickness

Seizures

Double vision

Difficulty swallowing

Difficulty walking

Headaches

Ear noises/Tinnitus

Hoarseness of voice

Nausea

Tremor

Unsteadiness

Electric shocks in arms/legs

Vomiting

Numbness in groin/Sexual dysfunction

Dizzy: If yes, do you feel light headed or as if you are spinning?

EXERCISE

None Activity / Duration _____

MENTAL STATUS

- Memory problems
- Depression
- Anxiety
- TIAs
- Personality change
- _____

ENDOCRINE

- Hair loss
- Gout
- Bruising
- Rash
- Dry Skin
- _____

IML/SYMPATHETIC

- Increased sweating
- Slow wound healing
- Cold hands/feet
- Incomplete bladder emptying
- Frequent urination
- ED

- Dry eye(s)
- Excessive tearing
- Dry mouth

CARDIOVASCULAR

- High blood pressure
- Heart attack
- Shortness of breath
- Stroke
- Heart palpitations
- Chest pain
- Aneurysm
- Fainting
- Pacemaker/Defib.

FEMALES ONLY

- Pregnant
- Cramps
- Menopausal
- Breast lumps
- Last menstrual period _____
- Last pelvic exam _____

PSYCHOSOCIAL

- Alcohol Social Light Heavy
 Recreational drug use None past _____ present _____
 Tobacco Current ___/day Former ___ years
 Stress level Low moderate high

FAMILY HISTORY PART 1 (Have any of your family members ever suffered from the following?)

- Cancer
- Epilepsy
- Other _____
- Diabetes
- Spinal problems
- Stroke
- Headaches
- Other _____
- Heart Attack

___ # of children. Any health problems? _____

FAMILY HISTORY PART 2 I was adopted

- | | | | |
|----------------------|--|--|------------------|
| Mother | <input type="checkbox"/> alive & well, age ___ | <input type="checkbox"/> deceased, age ___ | From what? _____ |
| Father | <input type="checkbox"/> alive & well, age ___ | <input type="checkbox"/> deceased, age ___ | From what? _____ |
| Sister | <input type="checkbox"/> alive & well, age ___ | <input type="checkbox"/> deceased, age ___ | From what? _____ |
| Sister | <input type="checkbox"/> alive & well, age ___ | <input type="checkbox"/> deceased, age ___ | From what? _____ |
| Brother | <input type="checkbox"/> alive & well, age ___ | <input type="checkbox"/> deceased, age ___ | From what? _____ |
| Brother | <input type="checkbox"/> alive & well, age ___ | <input type="checkbox"/> deceased, age ___ | From what? _____ |
| Maternal grandmother | <input type="checkbox"/> alive & well, age ___ | <input type="checkbox"/> deceased, age ___ | From what? _____ |
| Maternal grandfather | <input type="checkbox"/> alive & well, age ___ | <input type="checkbox"/> deceased, age ___ | From what? _____ |
| Paternal grandmother | <input type="checkbox"/> alive & well, age ___ | <input type="checkbox"/> deceased, age ___ | From what? _____ |
| Paternal grandfather | <input type="checkbox"/> alive & well, age ___ | <input type="checkbox"/> deceased, age ___ | From what? _____ |

CURRENT MEDICATIONS, VITAMINS, MINERALS, SUPPLEMENTS (PLEASE INCLUDE NAME, DOSAGE & PURPOSE)

PRIOR SURGERY, HOSPITALIZATIONS

(Where, when, what for?)

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR HEALTH?

