RICHARD R SHAKER, D.C., P.A.
PERSONAL HISTORY

Date_____

Name _____Address _____

City _____ State_____ Zip _____

Home Phone _____Business Phone _____Cell Phone_____

E-Mail _____Social Security Number _____

Birthdate _____ Age _____ Sex Male Female Married/Single/Widowed/Divorced/Separated

Employer _____ Type of Work _____ Phone#_____

Name & # of Emergency Contact _____Relationship _____# of Children ____

How did you hear about our office? _____Injury, Illness, or Condition _____

What other doctors have you seen? _____

Type of treatment _____ Results _____

Do you suffer from any condition other than that which you are now consulting us?
_____

Is this condition related to an Auto Accident? Yes/No If yes when was the accident? _____

Is this condition related to a Worker's Comp Injury? Yes/No If yes when?_____

Have you been to a chiropractor this year? YES/NO How many visits this year?_____

Have you been to a physical therapist this year? YES/NO How many visits this year_____

Have you been treated for any health condition in the last year? Y N If yes, please explain
_____

I am here for:____Chiropractic Care ____Disc Decompression ____Laser ____Trigenics Treatments

UNDERLINE conditions you have had **PREVIOUSLY** and **CIRCLE** conditions you have **NOW**

Diabetes	Cancer	Heart Disease
Low Back Pain	Pain Between Shoulders	Neck Pain
Arm Pain	Joint Pain/Stiffness	Walking Problems
Numbness	Paralysis	Difficulty Chewing/Clicking Jaw
Dizziness	Forgetfulness	Confusion/Depression
Fainting	Convulsions	Cold/Tingling Extremities
Allergies	Loss of Sleep	Fever
Headaches	Sinus Trouble	Digestive Disturbances
Blood Pressure		

Female Patient: Date of last period?_____ Pregnant Yes/No/Not sure

Patient's Signature _____

Name_____Date_____

USE THE LETTERS BELOW AND CIRCLE THE AREA TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

A = ACHE
P = PINS & NEEDLES

B = BURNING
S = STABBING

N = NUMBNESS
O = OTHER

Additional Comments:

For each of the six categories of daily living listed PLEASE CIRCLE THE NUMBER WHICH BEST DECRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. A score of 0 means no disability at all, and a score o
10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

1. Family/Home Responsibilities. This category refers to activities related to the home or family. It includes chores and duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

0 1 2 3 4 5 6 7 8 9 10
Completely able to function — Totally unable to function

2. Recreation. This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10
Completely able to function — Totally unable to function

3. *Social Activity.* This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties**,** theater, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9 10
Completely able to function — Totally unable to function

4. Occupation. This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as the homemaker or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10
Completely able to function — Totally unable to function

***5.* Self Care.** This category includes activities, which involve personal maintenance and independent daily living (e.g.,taking a shower, driving, getting dressed, etc.).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

6. Life-Support Activity. This category refers to basic life-supporting behaviors such as eating. sleeping, and breathing.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

I understand that fees are payable at the time of service unless other arrangements are made in advance or I am a member of an insurance group that has made prior arrangements for my care with this office. I am responsible for my full co-payment and/or deductible on each visit. I understand that x-rays are the property of the clinic, however, I may borrow the films and receive reports. I understand and agree that health and accident policies are an agreement between my insurance company and myself. I understand that Shaker Chiropractic will prepare all necessary reports and forms in order to collect the proper amounts from my company. I understand that I am personally responsible for any deductible,
Co-payments, or non-covered services, or nonpayment by the insurer for any reason. I understand that Shaker Chiropractic can only verify and not guarantee benefits from my insurer. Knowing my benefits is my responsibility. I understand that when I terminate care that all fees are immediately due and payable unless other arrangements are made
In writing. I authorize this office to furnish requested information to my insurer or attorney with a properly signed release.

If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient's Signature_____ Date_____

Consent to Treat a Minor_____ Date_____

Guardian or Spouse's Signature of Authorizing Care_____