



# FIALKOV CHIROPRACTIC



ROSS A. FIALKOV, D.C. - ORMOND BEACH, FL

## PATIENT INFORMATION

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M F Married  Single  Other

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_

Occupation \_\_\_\_\_ Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_

Social Security Number \_\_\_\_\_

Email Address \_\_\_\_\_ Circle YES to receive our bimonthly newsletter via Email

## INSURANCE INFORMATION

Do you have insurance which covers chiropractic treatment? YES NO (If NO skip this section)

Do you have health insurance where you work? YES NO FECA/Group # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Plan ID # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured same as patient YES NO (If yes then skip next 3 lines)

Patient Relationship to Insured Self Spouse Child Other

Insured Name \_\_\_\_\_ Insured Address \_\_\_\_\_

Insured D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured Gender M F Insured Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_



# Review of Systems

- Yes No Do you ever have skin, hair, or nail problems? \_\_\_\_\_
- Yes No Have you recently had any rashes/blistering? \_\_\_\_\_
- Yes No Do you ever have mouth or throat problems? \_\_\_\_\_
- Yes No Do you ever have nose or sinus problems? \_\_\_\_\_
- Yes No Do you have hearing or other ear problems? \_\_\_\_\_
- Yes No Do you have visual problems? \_\_\_\_\_
- Yes No Do you have recurring headaches/migraines? \_\_\_\_\_
- Yes No Do you ever have chest, lung, or breathing problems? \_\_\_\_\_
- Yes No Do you suffer from airborne allergies? \_\_\_\_\_
- Yes No Do you have any food allergies? \_\_\_\_\_
- Yes No Do you ever have recurring infections? \_\_\_\_\_
- Yes No Do you smoke? Cigarettes per day? \_\_\_\_\_ How long? \_\_\_\_\_
- Yes No Do you ever have heart or blood vessel problems? \_\_\_\_\_
- Yes No Do you have high cholesterol or blood pressure? \_\_\_\_\_
- Yes No Have you ever suffered a stroke or heart attack? \_\_\_\_\_
- Yes No Do you ever have blood or lymph node problems? \_\_\_\_\_
- Yes No Do you ever have digestive problems? \_\_\_\_\_
- Yes No Does your stomach get upset easily? \_\_\_\_\_
- Yes No Do you ever have genital problems? \_\_\_\_\_
- Yes No Do you ever have urinary or bowel problems/infections? \_\_\_\_\_
- Yes No Do you have frequent bouts of diarrhea or constipation? \_\_\_\_\_
- Yes No Do you have any nervous system diseases or mental health problems? \_\_\_\_\_
- Yes No Have you ever suffered from depression? \_\_\_\_\_
- Yes No Do you have any ticks or twitches? \_\_\_\_\_
- Yes No Do you ever have gland or hormone problems? \_\_\_\_\_
- Yes No Are you Diabetic? \_\_\_\_\_
- Yes No Do you ever have numbness or tingling? \_\_\_\_\_
- Yes No Do you ever have immunity problems? \_\_\_\_\_
- Yes No Do you recently feel weakness or fatigue more than in the past? \_\_\_\_\_
- Yes No Do you ever have muscle, tendon, or ligament problems? \_\_\_\_\_
- Yes No Do you have any bone or joint diseases like osteoporosis or arthritis? \_\_\_\_\_
- Yes No Have you ever been diagnosed with cancer? \_\_\_\_\_
- Yes No Does your pain wake you up at night? \_\_\_\_\_
- Yes No Have you had any recent weight gain or loss? \_\_\_\_\_
- Yes No Do you ever have sores that are slow to heal? \_\_\_\_\_
- Yes No

**FEMALES** Do you ever have menstrual problems? \_\_\_\_\_

Yes No Do you take birth control? How long? \_\_\_\_\_

Yes No Is there a chance you are currently pregnant? \_\_\_\_\_

# Presenting Problem

What is the presenting problem/chief complaint? \_\_\_\_\_

When did the problem begin? \_\_\_\_\_

What was the mechanism/cause of injury? \_\_\_\_\_

Where is the pain located? \_\_\_\_\_

Describe the pain (ie burning, sharp, shooting, aching, boring, etc) \_\_\_\_\_

Rate the pain as it is right now, 0-10 with 0 being no pain and 10 being most excruciating pain. \_\_\_\_\_

Rate the pain when it's at its worst, 0-10 \_\_\_\_\_

Does anything alleviate the pain? \_\_\_\_\_

Does anything exacerbate the pain? \_\_\_\_\_

Does the pain radiate into the extremities? \_\_\_\_\_

Is the pain worse or better at any time of the day? If so, when? \_\_\_\_\_

Are there any other associated symptoms? \_\_\_\_\_

Does the pain affect any of your normal daily activities? What/How? \_\_\_\_\_

Have you sought any medical attention for this complaint yet? If so, who did you see and what was the therapy? \_\_\_\_\_

What kind of other treatment have you sought for this problem? \_\_\_\_\_

Have you had any imaging for this problem (Xray, MRI, CT, etc.)? \_\_\_\_\_

Describe below any other problems you have been experiencing related or unrelated to the chief complaint

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Office use only:

ICD9:

<b>C</b>	str/spr 847.0	seg dys 739.1	IVD syn 722.0	Cervico-cranial syn 723.2	cerv/brach ial syn 723.3	brach rad/neur 723.4
<b>T</b>	str/spr 847.1	seg dys 739.2	IVD syn 722.11	Intcost nuer 729.2/353.8	costovert dys 739.8	TOS 353.0
<b>L</b>	str/spr 847.2	seg dys 739.3	IVD syn 722.10	Facet syn 724.8	Sciatica 724.3	
<b>S</b>	SI str/spr 846.1/846.9	SI seg dys 739.4		Lumbosacral str/spr 846.0		Other:

Severity:      1      2      3      Clinical Decision:      Straightforward      Low      Moderate      High

Physician: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_