James D Reade DC PLLC dba ARIZONA FAMILY HEALTH CENTRE

2430 W Ray Rd, #1, Chandler, AZ 85224 (480)732-0911 office (480)812-0533 fax

Patient Registration and History Questionnaire

WELCOME TO OUR OFFICE

By completing this form thoroughly, this will help the doctor assist you with your complaints. If you have any questions do not hesitate to speak to a staff member.

Referred by: _____

Name: _____ Age: _____ Date of birth: _____ Date: _____
LAST FIRST MIDDLE

Address: _____ Social Security #: _____ ☐ Male ☐ Female

City, State, Zip: _____ Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children_____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Email: _____

Employer: _____ Spouse's Name: _____

Occupation: _____ Spouse's Employer: _____

In case of emergency, notify_____ **Relationship:** _____ **Phone (_____)** _____

Chief Complaint or Reason for Office Visit: _____

Specific Date and Time of Onset of Symptoms: _____

Cause of Symptoms:_____

What makes your symptoms **better**? _____ What makes your symptoms **worse**? _____

What is the quality of your symptoms? (**ache, burn, dull, sharp, throbbing**): _____

Intensity of Symptoms (1-10) 0 = No Pain up to 10 being worse: 0 1 2 3 4 5 6 7 8 9 10

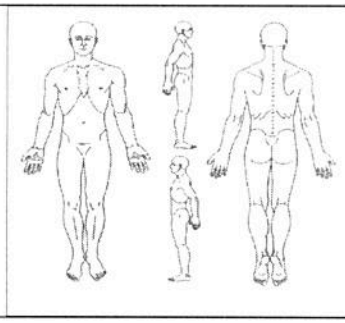
Are your symptoms local or do they travel to another area? (If they travel, where to?) _____

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other: _____

Are symptoms; ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% **of your waking hours**

Please mark on the diagram to the right the following symbols as they relate to your symptoms:

SS = spasms	ST = stiffness
DP = dull pain	SP = sharp pain
SH = shooting pain	TI = tingling
NU = numbness	O = Other



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Patient's Name: _____ Date: _____

Please list all medications and dosage: **Frequency** **For What Illness?**

_____

_____

List any allergies to medications, foods or other: _____

Are you pregnant? ☐ Yes ☐ No First day of last menstrual cycle: _____

Do you smoke? ☐ Yes ☐ No; How much? _____ Do you drink alcohol? ☐ Yes ☐ No; How much? _____

Please list all serious illness and serious accidents: **Month and Year** **City, State**

_____

_____

_____

Please list any recent X-rays, lab or other tests: Approximate Date, Facility/Doctor where performed

_____

_____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES:

Tuberculosis	☐ Yes	Lung Disease	☐ Yes	Gout	☐ Yes	Diabetes	☐ Yes
Kidney Disease	☐ Yes	Stomach/Ulcer	☐ Yes	Heart Disease	☐ Yes	Hepatitis	☐ Yes
Sciatica	☐ Yes	Blood Pressure	☐ Yes	Transfusion	☐ Yes	Polio / MS	☐ Yes
Colon Disease	☐ Yes	Stroke	☐ Yes	Cancer	☐ Yes	Bleeding	☐ Yes
Paralysis	☐ Yes	Seizures	☐ Yes	Arthritis	☐ Yes	Asthma	☐ Yes
Anemia	☐ Yes	Thyroid Disease	☐ Yes	Drug Dependence	☐ Yes	AIDS	☐ Yes

Any other condition(s) or complaints not listed above that the doctor should be made aware of:

_____

FAMILY HEALTH INFORMATION:

	Grandparents	Parents	Siblings
Cancer	☐	☐	☐
Heart Disease	☐	☐	☐
Diabetes	☐	☐	☐
Inflammatory Diseases	☐	☐	☐

i.e. arthritis, lupus, hashimoto's, celiac, auto immune disease, etc.

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Patient's Name: _____ Date: _____

Have you had previous chiropractic care? ☐ Yes ☐ No If yes, type of treatment: ☐ Gentle/Non-Force ☐ Forceful

☐ Don't know ☐ Physical Therapies Were you satisfied with this type of care? If no, why _____

Are you interested in getting to the root cause of your problem? ☐ Yes ☐ No ☐ Just give me pain relief

Are you interested in other treatments such as acupuncture, laser, nutrition that might help? ☐ Yes ☐ No

YOUR PRIMARY HEALTH INSURANCE COMPANY: _____

Address: _____ Telephone: (_____) _____

Insured/Subscriber Name/Relationship: _____ Subscriber Date of Birth: _____

Policy #: _____ Group #: _____ Subscriber SS#: _____

YOUR SECONDARY HEALTH INSURANCE COMPANY: _____

Address: _____ Telephone: (_____) _____

Insured/Subscriber Name/Relationship: _____ Subscriber Date of Birth: _____

Policy #: _____ Group #: _____ Subscriber SS#: _____

HIPAA Compliance

Who may receive information regarding your Protected Health Insurance? (Check all that apply)
☐ Spouse (as listed above) ☐ Significant Other/Friend – Name and DOB: _____
☐ Children: Name and DOB: _____ Name and DOB: _____

We normally leave messages on your voice mail, an answering machine, or email regarding appointments, test results or questions regarding insurance. If you **do not** want us to leave these messages, please let us know how you want to be contacted:_____

Dr. James D. Reade is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

I authorize payment of chiropractic benefits to Dr. James D. Reade. I accept responsibility for all my accrued charges that my insurance company may or may not cover at the level anticipated. Additionally, I understand that should my insurance company delay payment, I will be billed and responsible for the entire balance.

Patient Signature: _____ Date:_____

Witness: _____ Date: _____

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Patient_____ **Date**_____

PATIENT HISTORY REVIEW OF SYSTEMS

0 = NEVER HAD **1 = PATIENT PRESENTLY HAS** **2 = PREVIOUSLY HAD**

GENERAL	MUSCULOSKELETAL	NEUROLOGICAL
Recent weight gain	Arthritis	Lightheaded/Dizzy
Recent weight Loss	Rheumatoid Arthritis	Memory Loss
Fatigue	Broken Bones	Headaches
Fever	Osteoporosis	Migraines
Allergies	Gout	Numbness
Loss of appetite	Scoliosis	Weakness
Chills	Spinal Trauma	Stroke
Cancer of Any Kind	Joint Pain (anywhere)	Tingling/Numbness
CARDIOVASCULAR	**RESPIRATORY**	**INTEGUMENTARY (SKIN)**
Heart Attack	Coughing	Bruise Easily
Swelling of Ankles	Coughing Up Blood	Skin Rashes
High Blood Pressure	Chronic Cough	Discolorations
Low Blood Pressure	Chest Pain	Psoriasis
Shortness of Breath	Asthma	Changes in Moles
Pain Down Left Arm	Pneumonia	Sores
Profuse sweating	Bronchitis	Scars
High Cholesterol	Tuberculosis	Itching
EYES, EARS NOSE & THROAT	**GASTROINTESTINAL**	**GENITOURINARY**
Blurred Vision	Gall Bladder Problems	Painful Urination
Double Vision	Liver Problems	Blood in Urine
Ear pain	Pain over Stomach	Frequent Urination
Hoarseness	Ulcers	Kidney Infection
Nose Bleeds	Colitis	Kidney Stones
Glaucoma	Hiatal Hernia	Incontinence
Dental problems	Blood in Stool	

Other/Explanations:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature _____

**********PATIENTS STOP HERE: DO NOT COMPLETE OTHER SIDE. PAGE 1 FOR DOCTOR USE ONLY ********** Page 2