Full Circle Chiropractic

DR. BETTY SUTLIFF
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Name: _____ Today's Date: _____ Gender: M / F
PO Box: _____ Date of Birth: _____ Age: _____
St. Address: _____ Height: _____ Weight: _____
City/State/Zip: _____ Driver's Lic #: _____ State: _____
Phone# Home: _____ Marital Status (optional): _____
Work: _____ Name of Spouse: _____
Cell: _____ Spouse Occupation: _____
Social Security# (Optional) _____ Spouse Employer: _____
Occupation: _____ Spouse Work Phone: _____
Employer: _____ Refered By: _____
EMERGENCY CONTACT AND PHONE NUMBER: _____

Please Check any of these areas that you may be experiencing Difficulties : R=Right / L=Left

- ☐ HEADACHE
- ☐ SINUS
- ☐ DIZZINESS
- ☐ NAUSEA
- ☐ EAR R / L
- ☐ EYE R / L
- ☐ BLURRED VISION
- ☐ JAW PAIN R / L
- ☐ NECK PAIN
- ☐ NECK STIFFNESS
- ☐ SHOULDER R / L
- ☐ ARM PAIN R / L
  - ☐ NUMBNESS
  - ☐ TINGLING
- ☐ HAND PAIN R / L
  - ☐ NUMBNESS
  - ☐ TINGLING
- ☐ FINGER
  R T 1 2 3 4
  L T 1 2 3 4

BACK PAIN / STIFF

- ☐ UPPER
- ☐ MID
- ☐ LOWER
- ☐ SACRUM
- ☐ TAILBONE
- ☐ HIP PAIN R / L
- ☐ LEG PAIN R / L
- ☐ NUMBNESS
- ☐ TINGLING

- ☐ KNEE R / L
- ☐ ANKLE R / L
- ☐ FOOT R / L
- ☐ TOES R / L
- ☐ OSTEOPOROSIS
- ☐ ARTHRITIS
- ☐ DIABETES
- ☐ DIGESTION
- ☐ INSOMNIA
- ☐ FATIGUE

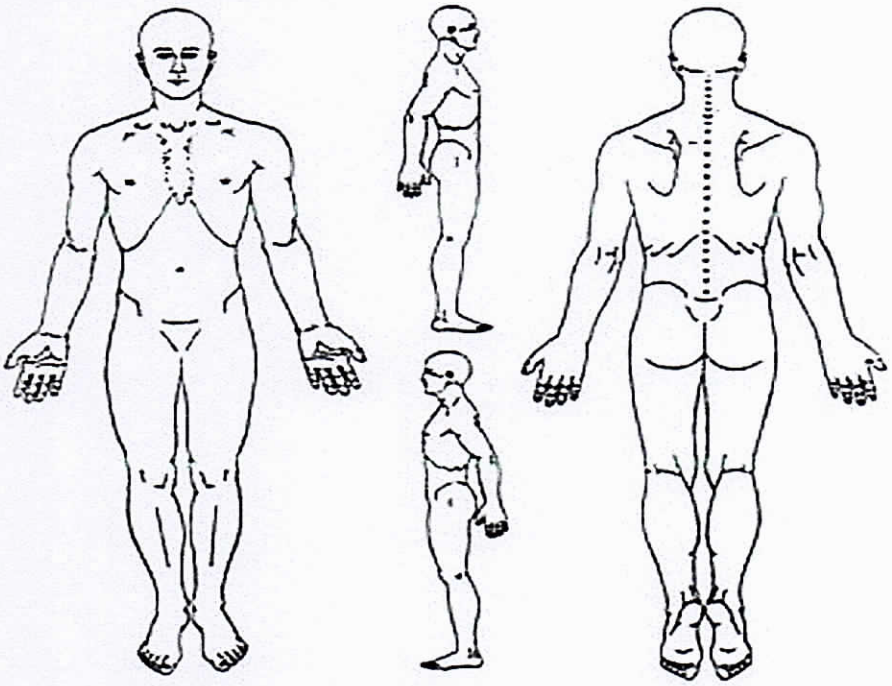
- ☐ LUNGS
- ☐ ASTHMA
- ☐ HEART
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ ALLERGIES

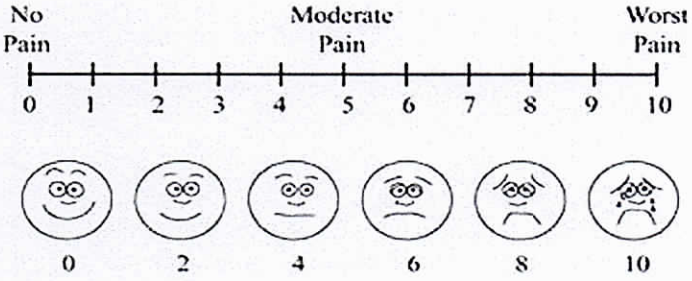
_____
_____

MAJOR COMPLAINTS: _____
_____
When did you notice this? _____ Have you had this before? Y / N When: _____
Was this caused by an accident or injury? Y / N Describe: _____
Have you lost days of work? Y / N Describe: _____ When: _____
Have you seen another physician for this condition? Y / N Whom and When: _____
XRAYS / MRI / CT SCAN (circle) Date: _____ Place: _____
List areas of Xray/MRI/CT: _____
Were you hospitalized for this condition? Y / N Admission Date: _____
List of Medications you are now taking: _____
_____
Have you had any type of Surgery? Y / N List types and dates of surgery below: _____
_____
Have you had any fractured or broken bones? Y / N Please List : _____
List any other accidents or injuries that you have had: _____
_____
Are you PREGNANT at this time? Y / N Due Date: _____
Have you had Chiropractic Care before? Y / N _____
Name of Doctor: _____ Phone#: _____

Method Of Payment : Health Insurance ___ Cash ___ Auto Accident ___ Workman's Comp ___

Please mark the areas of major complaint(s) and the level of intensity of the pain:





AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT OF BENEFITS:

I, hereby authorize Full Circle Chiropractic, PC to release any information acquired in the course of my examination and treatment concerning my physical condition in order to process any claim or reimbursement of charges incurred at this office. I, hereby authorize payment of benefits for services rendered by Full Circle Chiropractic, PC, to be paid directly to Full Circle Chiropractic, PC. This authorization for assignment of benefits will be in continual effect until revoked by both parties. I understand that I am ultimately responsible for my charges.

SIGNATURE _____ DATE _____

CONSENT TO AUTHORIZE TREATMENT:

I, hereby consent to receive treatment at Full Circle Chiropractic for **myself** or authorize treatment for **my child.**

PATIENT SIGNATURE **OR** GUARDIAN SIGNATURE _____ PRINT NAME _____ DATE _____