Rotella Chiropractic & Acupuncture Center

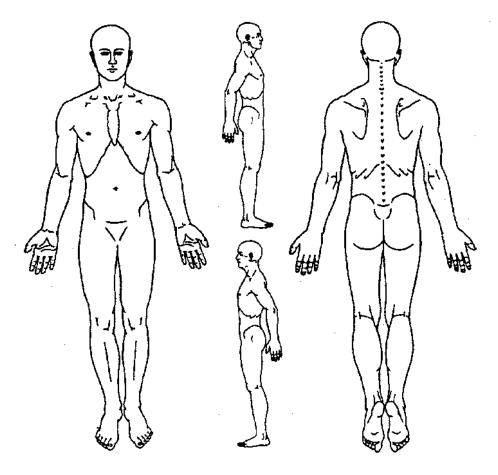
Patient Information

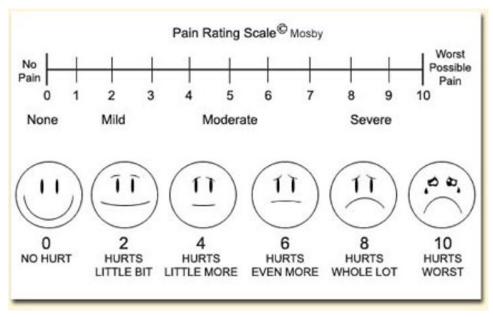
Thank you for choosing our practice for your Chiropractic, Acupuncture, herbal and nutritional needs. Please complete this form. Please note that information provided on this form is confidential. It is very important the information given are complete and accurate to assist you properly in your healing process. If you have any questions or concerns, do not hesitate to ask for assistance.

(Please Print)								
Name First				Date				
First		MI	Last					
Address				_City		State	Zip	
Sex:Fen	nale	Male	Transge	nder/Inter	sex(Other		
Birth Date								
Home Phone			_ Cell Phone		Wo1	k Phone		
Do you prefer Is it ok to leav					Work	Cell	Doesn't matter	
Email address	S							
Is it ok to send	d newsl	etter via em	ail	Is it	ok to sen	d appointme	nt reminders	
Are you:N Occupation				_Widowe	dSing	gleSepara	ated Partnered	
For minor's o	nly - pa	rent's name	e					
How did you	hear ab	out us?						
Person to contact in case of emergency					Phone			
Patient Co								
When did you	u first i	notice the s	ymptoms?					
Where is the	tion g probler	etting prog n located?_	gressively w	orse?				
Please list all	medica	tions, vitam	ins and herbs	s you are c	urrently 1	taking:		
Allergies:								
•	infectio	ons, lice, mi	ites, warts, in	npetigo, e			wounds, scabies, HIV, Hepatitis, case	

Mark the diagram with pain and type of pain:

 $A-ACHE\ B-BURNING\ N-NUMBNESS\ P-PINS\ \&\ NEEDLES\ S-STABBING\ O-OTHER.$





Rate the severity of your pain from 0 to 10

Please mark any of the follow	wing conditions or symptoms that you o	currently have:					
Other Symptoms:							
Other Symptoms: Headaches	Pain in Hands or Arms	Chest Pains					
Neck Pain	Numbness in Hands or Arms	Heart Attack					
Sleeping Problems	Pain in Legs or Feet	High Blood Pressure					
Low Back Pain	Numbness in Legs or Feet	Stroke					
Nervousness	Fatigue	Cancer					
Tension	Depression	Painful Urination					
Irritability	Lights Bother Eyes	Diabetes					
Dizziness	Loss of Memory	Diarrhea					
Pain Between Shoulders	Shoulder Pain	— Constipation					
Neck Stiff	Sinus	Stomach Upset					
Joint Swelling	Shortness of Breath	Heartburn/Reflux					
Fever	Asthma	Weight Loss					
Loss of Balance	Allergies	Loss of Smell or Taste					
Ringing in Ears	Cold Hands	Menstrual Cramps					
Jaw/TMJ Problems	Cold Feet	Menopause					
Date of last physical exam Are you pregnant: Yes No Taking Birth control pills Yes No							
emergencies or obligation an appointment, you may be treatment. Conversely, the we are unable to schedule Patient, who fail to show fewithin 48 hours of their sc	are times when you must miss an ap is for work or family. However, whe be preventing another patient from g e situation may arise where another you for a visit, due to a seemingly 'for their scheduled appointment, or the cheduled appointment time, shall be the amount equal to the treatment sess the en exception.	en you do not call to cancel getting much needed patient fails to cancel and "full" appointment book. did not notify the office subject to a "No					
knowledge. I understand to be responsible for paym dependents. I will be responsible for payments. I will be responsible for penalties, cancell	nd understand the above information that providing incorrect information that providing incorrect information that of all services rendered on my bonsible for any outstanding sums dustaion fees, return check fees, and all as insible for additional fees for returner awn from my account.	n can be dangerous. I agree behalf or that of my e to this office, including ll collection fees. I am					
X Signature of patient ((or parent if a minor) Da	ate					