Roff & Schilsky Chiropractic Center

200 E. Roosevelt St. • Dillon, SC 29536
(843) 627-3222 • Fax (843) 627-3223
Dr. Suezen R. Schilsky

ACCT# _____ DATE: _____

LAST NAME: _____ FIRST NAME: _____ MI:____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____

MAILING ADDRESS: _____ CITY: _____ ZIP:_____

EMAIL ADDRESS: _____ AGE: _____ DATE OF BIRTH: _____

OCCUPATION: _____ EMPLOYER:_____

WORK STATUS: FULL ____ OR PART TIME____ STUDENT: FULL TIME ____ OR PART TIME ____

DRIVER'S LICENSE #: _____ STATE:_____

FAMILY PHYSICIAN: _____

EMERGENCY CONTACT PERSON: _____ RELATIONSHIP: _____

I HEREBY AUTHORIZE ROFF AND SCHILSKY CHIROPRACTIC CENTER TO EXAMINE ME, INCLUDING X-RAYS IF INDICATED BY MY EXAM, AND TO RELEASE MY RECORDS TO ANYONE I DESIGNATE. I FURTHER AUTHORIZE TREATMENTS DEEMED NECESSAY BY THE FINDINGS, AND WISH ALL MY CHIROPRACTIC RECORDS TO BE HELD IN STRICT CONFIDENCE AND NOT TO BE GIVEN TO ANYONE WITHOUT MY WRITTEN CONSENT. I AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR FROM MY INSURANCE COMPANY AND I CLEARLY UNDERSTAND THAT I AM TOTALLY RESPONSIBLE FOR PAYMENT SHOULD MY INSURANCE COMPANY DENY PAYMENT, OR MAKE PAYMENT DIRECTLY TO ME. FIRST DAYS FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE. BY SIGNING YOUR NAME BELOW, YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENT TO ROFF AND SCHILSKY CHIROPRACTIC CENTER FOR EVALUATION AND TREATMENT OF A HEALTH RELATED CONDITION AND NO OTHER PURPOSE.

_____

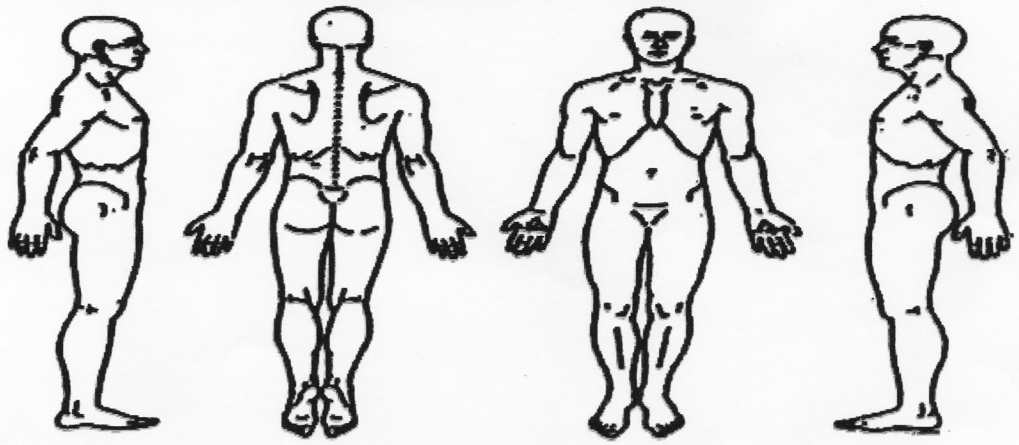
Signature of patient or guardian care Date

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ **Weight** _____ **Date of Birth** _____

Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present
□	□	Headaches	□	□	High Blood Pressure	□	□ Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□ Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□ Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□ Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□ Drug/Alcohol Dependance
□	□	Shoulder Pain	□	□	Kidney Stones	□	□ Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□ Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□ Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□ Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□ HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss		
□	□	Ankle/Foot Pain	□	□	Loss of Appetite		**For Females Only**
□	□	Jaw Pain	□	□	Abdominal Pain	□	□ Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□ Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□ Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder		
□	□	Cancer	□	□	General Fatigue		
□	□	Tumor	□	□	Muscular Incoordination		
□	□	Asthma	□	□	Visual Disturbances		
□	□	Chronic Sinusitis	□	□	Dizziness		
□	□	Other:_____					

20. List all prescription medications you are currently taking:
_____

21. List all of the over-the-counter medications you are currently taking:
_____

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____