Root Cause RESOLUTION

CHIROPRACTIC & FUNCTIONAL MEDICINE

10040 W. Cheyenne Avenue, Suite 130
Las Vegas, Nevada 89129
(702) 820-5320
www.rootcauseresolution.life

Patient Information:

Name:			Date:
DOB:	Age:	Gender: □ Female □ Male	SSN:
Address:			
City:	State:		Zip:
Home #:	Cell #:		Work #:
Marital Status: □ Single □ Married □ Divorced □ Widowed			
Email:			
Emergency Contact:			Emergency Phone:
Employment Status: □ Employed □ Unemployed □ Student □ Retired □ Disabled			□ Full Time □ Part Time
Occupation:		Employer:	
Work Duties:			
How were you referred to our office?			
If patient is a minor: Parent/Guardian:		Relationship:	
Home #:	Cell #:		Work #:

Chiropractic Experience:

Have you seen a Chiropractor before? □ Yes □ No	Who?
If yes, how long were you treated?	Last Treatment Date:
Reason for visit(s):	

Personal Health History:

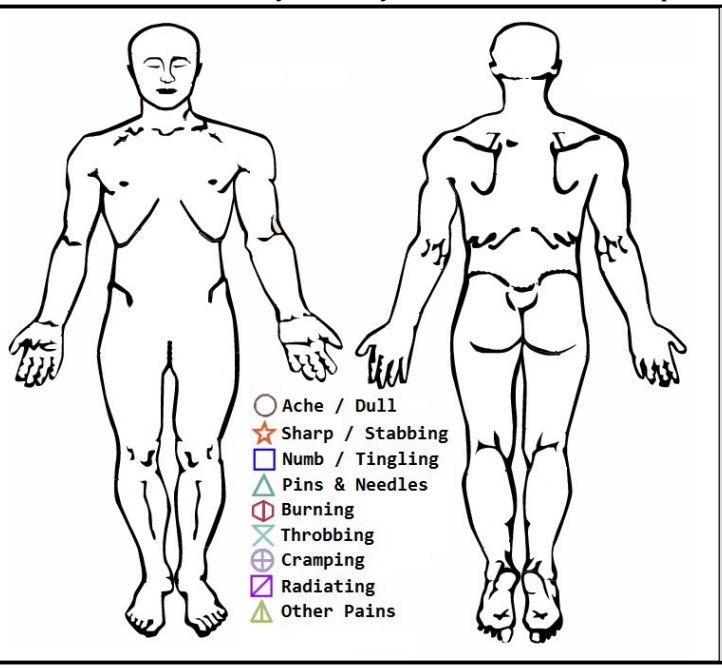
Last Physical Exam:	Primary Care Physician:	PCP Phone#:
Health Conditions:		
Medications:		
Supplements:		

Purpose for this visit:

What is your chief complaint?	
When did this condition begin?	
How did this condition begin?	
Is this related to an accident or injury? □ Yes □ N o	If yes, when?
Note: if the reason for your visit is the result of an accident or work-related injury, please see the front desk for additional corresponding documentation	
Have you experienced this condition before? □ Yes □ No	If yes, how often?
Have you seen anyone else for this condition? □ Yes □ No	If yes, who?
Did you receive a diagnosis? □ Yes □ No	If yes, what?
Have you had any imaging for this condition? □ CT Scan □ MRI □ X-rays	
What makes your condition feel better?	
What makes your condition feel worse?	
Describe how your condition feels? □ Achy/Dull Pain □ Sharp/Stabbing Pain □ Numb/Tingling Pain □ Pins & Needles Pain □ Burning Pain □ Throbbing Pain □ Cramping □ Radiating Pain □ Other If Other, please explain:	
If you have radiating pain is it radiating down your: □ Arms/Hands □ Legs/Feet	
On a scale of 1 to 10, 10 being the worst, what is the current level of your pain? □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10	
On a scale of 1 to 10, 10 being the worst, what is the level of your pain at its worst? □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10	
On a scale of 1 to 10, 10 being the worst, what is the level of your pain at its best? □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10	
Have your symptoms: □ Worsened □ Stayed Constant □ Comes and Goes	
Do your symptoms worsen at certain times of the day? □ AM □ PM	

Patient Symptoms:

Please take note to the symbol key and indicate the corresponding symbol/symptom on the body image provided.



For Office Use Only

How have your symptoms affected your everyday life:		
Interfere with activities:	□ Yes □ No	Explain:
Affect you sleep:	□ Yes □ No	Frequency:
Missed or Reduced work:	□ Yes □ No	Explain:
Affect appetite:	□ Yes □ No	Explain:
Do symptoms worsen:	□ Yes □ No	Explain:
Do symptoms improve:	□ Yes □ No	Explain:

Patient Social:

Please indicate how often you consume the following:								
Alcohol:	□ Daily	□ Weekly	□ Occasionally	□ Never	Caffeine:	□ Daily	□ Weekly	□ Occasionally	□ Never
Diet Food Products:	□ Daily	□ Weekly	□ Occasionally	□ Never	Drugs:	□ Daily	□ Weekly	□ Occasionally	□ Never
OTC Stimulants:	□ Daily	□ Weekly	□ Occasionally	□ Never	Exercise:	□ Daily	□ Weekly	□ Occasionally	□ Never
Homemade Food:	□ Daily	□ Weekly	□ Occasionally	□ Never	Processed Food:	□ Daily	□ Weekly	□ Occasionally	□ Never
Soft Drinks:	□ Daily	□ Weekly	□ Occasionally	□ Never	Tobacco:	□ Daily	□ Weekly	□ Occasionally	□ Never
Water	□ Daily	□ Weekly	□ Occasionally	□ Never					

For Women Only:

Are you pregnant?	□ Yes □ No	Do you experience painful periods?	□ Yes □ No
Are you nursing?	□ Yes □ No	Do you have irregular cycles?	□ Yes □ No
Are you taking birth control?	□ Yes □ No	Do you have breast implants?	□ Yes □ No

Personal Accident History:

Broken Bones:	□ Yes □ No	Treatment:	□ Yes □ No	Explain:
Sprains/Strains:	□ Yes □ No	Treatment:	□ Yes □ No	Explain:
Hospitalized:	□ Yes □ No	Explain:		
Surgery:	□ Yes □ No	Explain:		
Auto Accident:	□ Yes □ No	Treatment:	□ Yes □ No	Explain:
Struck Unconscious:	□ Yes □ No	Treatment:	□ Yes □ No	Explain:
Eating Disorder:	□ Yes □ No	Explain:		
Stroke:	□ Yes □ No	Explain:		

Family Health History:

Have you or any of your family ever been diagnosed with the following (please indicate "Y" for You and "O" for Other than you, or both if applicable:

□ Allergies_____	□ Alcoholism_____	□ Anemia
□ Arteriosclerosis_____	□ Arthritis_____	□ Asthma _____
□ Back Pain_____	□ Breast Lump_____	□ Bronchitis_____
□ Bruise Easily_____	□ Cancer_____	□ Chest Pain_____
□ Cold Extremities_____	□ Constipation_____	□ Cramps _____
□ Depression_____	□ Diabetes_____	□ Digestion Problems_____
□ Dizziness_____	□ Excessive Menstruation_____	□ Eye Pain or Difficulties_____
□ Fatigue_____	□ Frequent Urination_____	□ Headache _____
□ Hemorrhoids_____	□ Venereal Disease_____	□ Hot Flashes_____
□ Irregular Heart Beat_____	□ Irregular Menstruation_____	□ Kidney Infection_____
□ Kidney Stones_____	□ Loss of Memory_____	□ Loss of Balance _____
□ Loss of Smell_____	□ Loss of Taste_____	□ Nosebleeds _____
□ Pacemaker_____	□ Polio_____	□ Poor Posture _____
□ Prostate Troubles_____	□ Sciatica_____	□ Shortness of Breath_____
□ High Blood Pressure_____	□ Sinus Infection_____	□ Insomnia _____
□ Spinal Curvatures_____	□ Stroke_____	□ Swelling of Ankles _____
□ Swollen Joints_____	□ Thyroid Condition_____	□ Tuberculosis _____
□ Ulcers_____	□ Varicose Veins _____	

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature: _____ Date: _____