Dr. Jeff Zitel, D.C.

Zitel Family Chiropractic

(704) 544-8881

Toringdon 2 • 3430 Toringdon Way • Suite 107 • Charlotte, NC 28277

Name _____ Social Security # _____ Phone _____

Address _____ City _____ State _____ Zip _____

E-mail Address _____ Cell # _____ Provider: ☐ AT&T ☐ T-Mobile

Birth Date _____ Height ____ Weight ____ Marital: M S W D # of Children ____ ☐ Verizon ☐ Other

Occupation _____ Employer _____

Employer's Address _____ Office Phone _____

Spouse _____ Contact # _____ Employer _____

Emergency Contact _____ Address _____ Phone _____

How were you referred to our office? _____

Family Medical Doctor _____

Purpose of this appointment _____

Date symptoms appeared or accident occurred _____

Have you ever had the same or similar condition? ☐ Yes ☐ No If yes, when and describe _____

_____

Days lost from work _____ Date of last physical examination _____

What surgeries have you had (include dates) _____

Serious illnesses (include dates) _____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No

If yes, describe _____

What medications or drugs are you taking? _____

_____

Please check any and all insurance coverage that may be applicable in this case:

☐ Major Medical ☐ Secondary ☐ Worker's Compensation ☐ Auto Accident ☐ Other

Name of Primary Insurance Company _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, and fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

Doctor's Signature _____ Date _____

1. What is your major symptom?

2. What does this prevent you from doing or enjoying?

3. If this is a recurrence, when was the first time you noticed this problem?

How did it originally occur?

Has it become worse recently? Yes ☐ No ☐ Same ☐ Better ☐ Gradually Worse ☐

If yes, when and how?

4. How frequent is the condition? ☐ Constant 76-100% ☐ Frequent 51-75% ☐ Intermittent 26-50% ☐ Occasional 0-25%

When does it feel worse? ☐ No Change ☐ Morning ☐ As Day Progresses ☐ Afternoon ☐ Evening ☐ Nighttime

5. Are there any other conditions or symptoms that may be related to your major symptom? Yes ☐ No ☐

If yes, describe

Are there any other unrelated health problems? Yes ☐ No ☐ If yes, describe

6. Describe the pain: Sharp/Stabbing ☐ Dull ☐ Numbness/Tingling ☐ Stiff/Tight ☐ Aching ☐

Burning ☐ Throbbing ☐ Soreness ☐ Tenderness ☐ Other ☐

7. Is there anything you can do to relieve the problem? Yes ☐ No ☐ If yes, describe

If no, what have you tried to do that has not helped

8. What makes the problem worse? Standing ☐ Sitting ☐ Lying ☐ Bending ☐

Lifting ☐ Twisting ☐ Working ☐ Driving ☐ Walking ☐ Other ☐

9. Have you had any broken bones? Yes ☐ No ☐ If yes, please list and give dates

10. List any major accidents you have had other than those that might be mentioned above

11. To your knowledge, have you has any diseases, major illness, or injuries not indicated on this form either in the past or present? Yes ☐ No ☐ If yes, please explain

12. Are you pregnant or is there any possibility you may be pregnant?

Yes ☐ No ☐ Uncertain ☐ If yes, when is your due date?

13. Remarks you would like us to know

NO SYMPTOMS — EXTREME SYMPTOMS

Please place an "X" on the line to indicate level of problem

Doctor's Signature Date

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Patient Name _____ Date _____

	N= Now	P= Past	
Headaches _____ Frequency		Ulcers	
Neck Pain		Loss of Balance	
Stiff Neck		Fainting	
Sleeping Problems		Loss of Smell	
Back Pain		Loss of Taste	
Nervousness		Unusual Bowel Problems	
Tension		Feet Cold	
Irritability		Hands Cold	
Chest Pains/Tightness		Arthritis	
Dizziness		Muscle Spasms	
Shoulder/Neck/Arm Pain		Frequent Colds	
Numbness in Fingers		Fever	
Numbness in Toes		Sinus Problems	
High Blood Pressure		Diabetes	
Difficulty Urinating		Indigestion Problems	
Weakness in Extremities		Joint Pain/Swelling	
Breathing Problems		Menstrual Difficulties	
Fatigue		Weight Loss/Gain	
Lights Bother Eyes		Depression	
Ears Ring		Loss of Memory	
Broken Bones/Fractures		Buzzing in Ears	
Rheumatoid Arthritis		Circulation Problems	
Excessive Bleeding		Seizures/Epilepsy	
Osteoarthritis		Low Blood Pressure	
Pacemaker		Osteoporosis	
Stroke		Heart Disease	
Ruptures		Cancer	
Eating Disorder		Coughing Blood	
Drug Addiction		Alcoholism	
Gall Bladder Problems		HIV Positive	

Doctor's Signature _____ Date _____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN = "O" SOMETIMES = "S" NEVER = "N"

Vigorous Exercise	Family Pressures
Moderate Exercise	Financial Pressures
Alcohol Use	Other Mental Stress
Drug Use	Other (specify)
Tobacco Use	
Caffeine	
High Stress Activity	

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply.

CONDITION	FATHER Age ( )	MOTHER Age ( )	SPOUSE Age ( )	BROTHER(S) Age ( ) Age ( )	SISTER(S) Age ( ) Age ( )	CHILDREN Age ( ) Age ( )
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other						

If any of the above family members are deceased, please list their age at death and cause:

I certify the information provided is accurate to the best of my knowledge:

Signature of Patient/Legal Guardian _____ Date _____

Doctor's Signature _____ Date _____