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

Age____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
_____ Moderate Exercise
_____ Alcohol Use
_____ Drug Use
_____ Tobacco Use
_____ Caffeine
_____ High Stress Activity

_____ Family Pressures
_____ Financial Pressures
_____ Other Mental Stress
_____ Other (specify) _____

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 _____