# Burley-Stroker Chiropractic

**240 Magnolia Square Court, Aberdeen, NC 28315/910-944-1481**

**Patient Name** _____ **Date** _____

**Past/Current Medical Conditions:** *(Circle all conditions that apply to you)*

| | | | |
|---|---|---|---|
| Cancer | Hypertension | High Cholesterol | Heart Attack |
| Heart Arrhythmia | Stroke | Pace Maker | Peripheral Vascular Disease |
| Diabetes | Endocrine Disorders | Thyroid Disorders | Osteoporosis/Ostopenia |
| Allergies | HIV/AIDS | Blood Disorders | Autoimmune Disorders |
| Hepatitis | Kidney Disease/Stones | Gall Bladder Disorders | Head Trauma/Concussion |
| Migraine/Headaches | Seizures | Asthma | Emphysema/COPD |
| Glaucoma | Vision Disorders | Reflux/GERD | Arthritis |

**List Surgeries/Medications:** _____

_____

**Social History:** *(Circle all that apply to you)*

| | | | |
|---|---|---|---|
| Caffeine use: | occasional | often | never |
| Alcohol use: | occasional | often | never |
| Exercise habits: | occasional | often | never |
| Tobacco use: | occasional | often | never |
| Cigarettes: | <1 pack/day | >1 pack/day | never |
| Substance Abuse: | [ ] Past | [ ] Present | |

**Family History:** *(Circle all that apply)*

| | | | |
|---|---|---|---|
| Arthritis: | Parent | Sibling | Specify _____ |
| Cancer: | Parent | Sibling | Specify _____ |
| Diabetes: | Parent | Sibling | Specify _____ |
| Cardiovascular Disease: | Parent | Sibling | Specify _____ |

**Occupation:** _____

**Comments:** _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Scott G. Stroker, D.C.

***Please continue on back***

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**Patient Name** **Date**

**Review of Systems** - (Check appropriate box)

| Cardiovascular | Past | Present | Ear, Nose & Throat | Past | Present |
|---|---|---|---|---|---|
| Cold Hands/Feet | | | Difficulty Swallowing | | |
| Chest Pain | | | Hearing Loss | | |
| Jaw/Face Pain | | | Recurrent Sore Throat | | |
| Swelling of Legs | | | Recurrent Nosebleeds | | |
| Palpitations | | | Recurrent Bleeding Gums | | |
| Shortness of Breath | | | Recurrent Sinus Infections | | |
| Lightheadedness/Dizziness | | | **Constitutional** | | |
| **Respiratory** | | | Weight Gain/Loss | | |
| Wheezing | | | Poor Appetite | | |
| Fever | | | Unexplainable Fatigue | | |
| Frequent Cough | | | Restless Sleep | | |
| **Neurologic** | | | Depressed | | |
| Severe Head Pain | | | Anxious | | |
| Changes in Sensation | | | Irritable | | |
| Poor Concentration | | | Excessive Sweating | | |
| Forgetfulness | | | Night Sweating | | |
| Weakness | | | Hot Flashes | | |
| Poor Coordination | | | Cold Sensitivity | | |
| Ringing in Ears | | | **Gastrointestinal** | | |
| Blurred Vision/Double Vision | | | Constipation | | |
| **Genitourinary** | | | Diarrhea | | |
| Burning Urination | | | Changes in Color of Stool | | |
| Frequent Urination | | | Nausea/Vomiting | | |
| Discoloration of Urine | | | Heartburn | | |

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Who (or what source) referred you to this office? _____

Name: _____ Home Phone: _____
FIRST MIDDLE INITIAL LAST

Address: _____ / _____ / _____ / _____
CITY STATE ZIP CODE

Birth date: _____ Age: _____ Cell Phone #_____ Email: _____

What is your complaint(s): **PLEASE COMPLETE THE INFORMATION ON THE RESERVE SIDE.**

Have you seen any other doctor(s) for this condition or problem? [ ] Yes [ ] No.
If yes, please give the name of the doctor(s): _____

Is this complaint the result of an Auto accident? [ ] Yes [ ] No. A work related injury? [ ] Yes [ ] No.

Do you have Medical insurance? [ ] Yes [ ] No. Name of insurance company _____

**ASSIGNMENT OF BENEFITS/PATIENT'S AUTHORIZATION**

I hereby assign to Burley-Stroker Chiropractic all the benefits to which I might have entitlement, whether by first party or by third party coverage, to the extent of my bill for the treatment rendered to me, not to exceed the reasonable and customary changes for these services. I understand I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered to me. I, the patient, will be completely responsible for any remaining balance in any event that a balance may exist. Furthermore, I authorize the release of any medical information necessary to process this claim.

I have read and agree to be bound by the terms of the aforementioned authorization.

_____ _____
PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

I acknowledge that I have received and/or have been given the opportunity to review the Notice of Privacy for the protection of personal healthcare information.

Patient's Signature _____

Date _____

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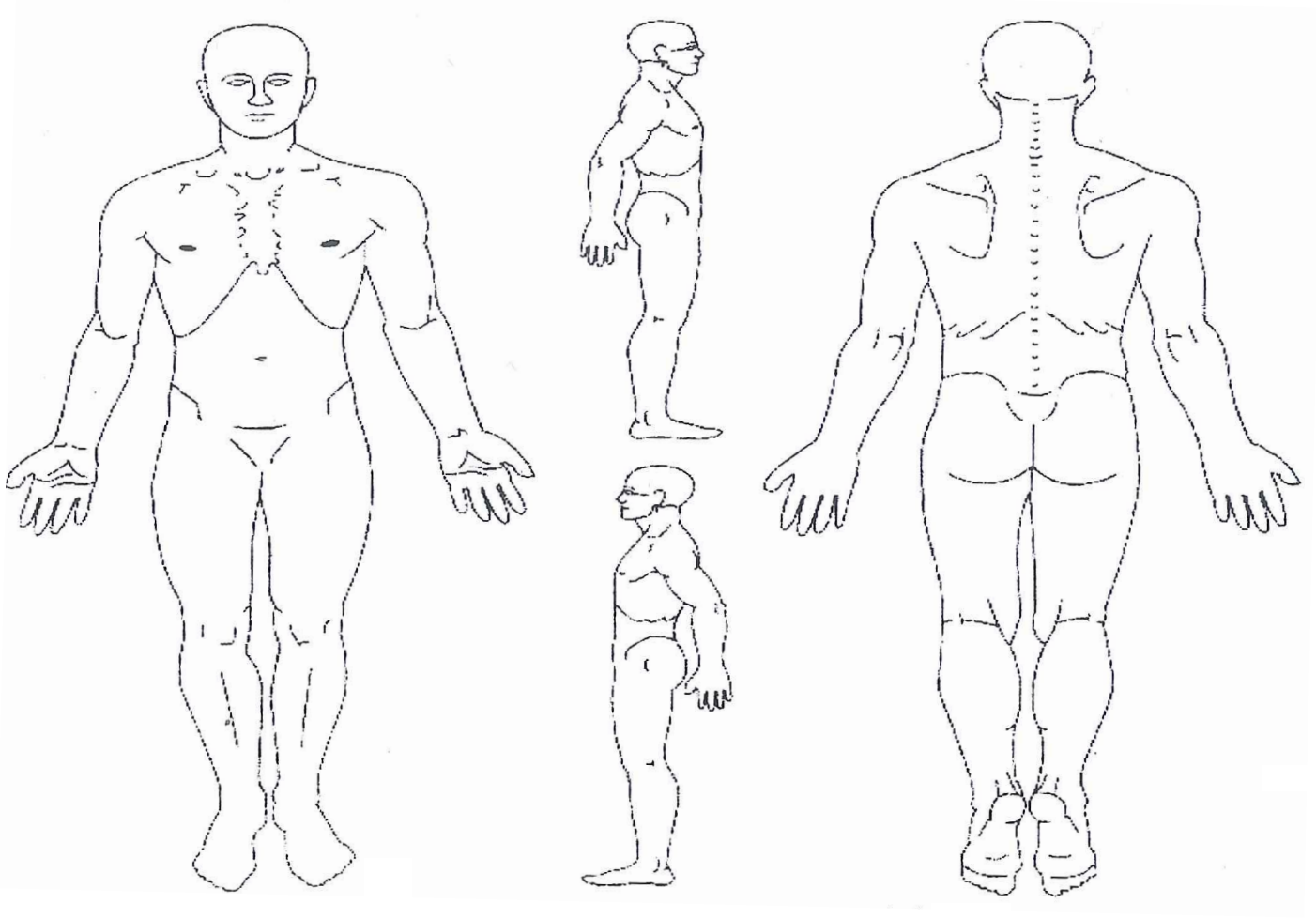
**Patient Name** **Date**

Are you pregnant? _____ Yes _____ No

Using the body diagram below, indicate where you are experiencing your symptoms:



When did your symptoms begin? Month _____ Day _____ Year _____

How did your symptoms begin? _____

_____

_____

_____

How often do you experience your symptoms?

| Constantly | Frequently | Occasionally | Intermittently |
|---|---|---|---|
| (76-100% of the day) | (51-75% of the day) | (26-50% of the day) | (0-25% of the day) |

What describes the nature of your symptoms?

Sharp Dull ache Numb Shooting Burning Tingling

Stabbing Other _____

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