

DR SCOTT JURICA, DC, PAK, ACN

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PLEASE PRINT

DATE: _____

PERSONAL INFORMATION

NAME _____ EMAIL _____ Signup for Newsletter: Y/N

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE (Work) _____ (Cell) _____ SSN. _____ DOB _____

MARITAL STATUS _____ SEX _____ AGE _____ NUMBER OF CHILDREN _____

OCCUPATION _____ EMPLOYER _____

ADDRESS _____ CITY/ZIP _____ TELEPHONE _____

NAME OF SPOUSE _____ SPOUSE'S OCCUPATION _____

EMPLOYER _____

ADDRESS _____ CITY/ZIP _____ TELEPHONE _____

EMERGENCY NOTIFICATION

NAME _____

ADDRESS _____ CITY/ZIP _____ TELEPHONE _____

REFERRED BY _____

CONSENT TO TREATMENT

I understand and agree that health and accident policies are an agreement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care and I give authority for these procedures to be performed. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the \$20 returned check charge in the event that my check is returned.

Date _____ Patient's Signature _____

24 HOUR CANCELLATION POLICY

In the event an appointment is missed without notifying the office within 24 hours, the patient will be charged for the appointment

Date _____ Patient Signature _____

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES

I hereby authorize Dr. Scott Jurica to release any information required in the course of my examination or treatment necessary to satisfy medical insurance claims.

Date _____ Patient's Signature _____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT _____

HOW DID IT HAPPEN? _____

TODAYS CONDITION STARTED WHEN? _____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? _____

WHAT ACTIVITIES LESSEN YOUR CONDITION? _____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY? _____

IS THIS CONDITION INTERFERING WITH WORK? _____ SLEEP? _____ ROUTINE? _____

IS CONDITION GETTING PROGRESSIVELY WORSE? _____

OTHER DOCTORS SEEN FOR THIS CONDITION _____

TYPE OF TREATMENT _____ RESULTS _____

Habits

- Alcohol: Type _____ Amount _____
- Diet: Salt intake _____ Fat intake _____ Other _____
- Sleep: Difficulty falling asleep _____
- Continuity disturbances _____
- Early morning awakenings _____
- Daytime drowsiness _____
- Other _____
- Smoking: Packs daily _____ How long _____ Interested in stopping? _____
- Exercise routine: _____
- Caffeine: Coffee, cups daily _____ Other _____

MEDICATIONS: _____

DRUG ALLERGIES: _____

Medical History

- RINGING IN EAR
- EAR INFECTIONS - FREQUENT
- DIZZINESS/FAINTING
- FAILING VISION
- EYE INFECTIONS
- NOSE BLEEDS
- SINUS TROUBLE
- SORE THROATS - FREQUENT
- HAYFEVER/ALLERGIES
- PNEUMONIA
- BRONCHITIS/CHRONIC COUGH
- ASTHMA/WHEEZING
- CHEST PAIN
- HIGH BLOOD PRESSURE
- HEART MURMUR
- SWOLLEN ANKLES
- LEG PAIN - WALKING
- VARICOSE VEINS/PHLEBITIS
- LOSS OF APPETITE
- DIFFICULTY SWALLOWING
- INDIGESTION OR HEARTBURN
- PERSISTENT NAUSEA/VOMITING
- PEPTIC ULCERS
- ABDOMINAL PAIN - CHRONIC
- GALL BLADDER TROUBLE
- JAUNDICE/HEPATITIS
- CHANGE IN BOWEL HABITS
- DIARRHEA CONSTIPATION
- DIVERTICULOSIS CROHN'S/COLITIS
- BLOODY OR TARRY STOOLS
- HEMORRHOIDS
- HERNIA
- URINE INFECTIONS - FREQUENT
- BLOOD IN URINE
- URINATION- OVERNIGHT > THAN TWICE
 - PAINFUL LOSS OF CONTROL
 - DECREASE IN FORCE/FLOW
- KIDNEY STONES
- VENEREAL DISEASE
- URETHRAL DISCHARGE
- CHRONIC FATIGUE
- WEIGHT LOSS - RECENT
- ANEMIA BRUISE EASILY
- CANCER
- DIABETES
- THYROID DISEASE
- CONVULSIONS/SEIZURES
- STROKE
- TREMOR/HANDS SHAKING
- MUSCLE WEAKNESS
- NUMBNESS/TINGLING SENSATIONS
- HEADACHES - FREQUENT
- ARTHRITIS/RHEUMATISM
- OSTEOPOROSIS
- BACK PAIN - RECURRENT
- BONE FRACTURE/JOINT INJURY
- GOUT
- FOOT PAIN COLD NUMB FEET
- RASHES HIVES
- PSORIASIS ECZEMA
- NERVOUSNESS DEPRESSION
- MEMORY LOSS
- MOODINESS - EXCESSIVE
- PHOBIAS
- MENTAL ILLNESS
- LACTOSE INTOLERANCE
- PROSTATE DISEASE
- SEXUAL/MENSTRUAL DYSFUNCTION
- FREQUENT INFECTIONS
- DIPHTHERIA
- TETANUS
- CHICKEN POX POLIO MUMPS
- MEASLES RUBELLA RHEUMATIC FEVER
- SCARLET FEVER TUBERCULOSIS HERPES
- OTHER _____
- OTHER _____

Females - Please Complete

PREGNANT? YES NO

PLANNING PREGNANCY? YES NO

Menstrual Flow:

Regular Irregular Pain/Cramps

____ Days of Flow ____ Length of Cycle

Date-1st day of last period _____

Pain/Bleeding during or after sex

Number of:

____ Pregnancies ____ Abortions

____ Miscarriages ____ Live Births

Birth Control Method _____

B.C. Pill (Name) _____

Flushing/Menopause

Date of Last PAP Test _____

Normal Abnormal

Date of Last Mammogram _____

Normal Abnormal

HOSPITALIZATIONS:

Date	Reason	Date	Reason

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:

HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP:

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH	ILLNESS	FAMILY MEMBER
FATHER				DIABETES	
MOTHER				CANCER	
BROTHERS AND SISTERS				BLOOD DISEASE	
				GLAUCOMA	
				EPILEPSY	
SPOUSE				RHEUMATOID	
				ARTHRITIS	
CHILDREN				TUBERCULOSIS	
				GOUT	

HIGH BLOOD
PRESSURE
HEART DISEASE
BACK
PROBLEMS

Insurance Information:

Do you have health insurance and/or Medicare? Yes No

Is your condition due to an auto accident or job related injury? Yes No

Insurance Company _____ Policy # _____

Policy Holder _____

Patient relationship to insured: Self ___ Spouse ___ Child ___ Other ___

Please read the following carefully:

I understand and agree that health and accident policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will answer reasonable administrative requests from your insurance carrier without additional fee. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, regardless of whether or not it's paid by the insurance carrier.

Patient's Signature _____ Date _____