Confidential Patient Information

Triangle CRC, PLLC
4817 Hargrove Rd Suite 105
Raleigh, NC 27616

(919) 792-8682 Phone
(919) 882-1774 Fax
www.TriangleCRC.com

Date:_____/______/_______

Patient's Full Name ____

Mailing Address:____ City:________________ State:_______ Zip:_____________

Cell Phone: _______-________-________ Additional Phone: _____-______-______ E-Mail: _______________________________

☐ Male ☐ Female Date of Birth:_____/____/______ ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Spouse's Name:_______________________ Number of Children/Ages____

Currently pregnant: ☐ Yes ☐ No

Who can we thank for your referral? ____

If no direct referral, how did you find us?____

Social Security # ________ - ________ - ________

Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Homemaker ☐ Unemployed

Occupation:_____________________ Employer:______________________

Emergency Contact:______________________________ Relationship:______________________ Phone: ____________________

Family Physician: __________________________ City: _________________________ State:__________ Phone________________

Previous Chiropractic Care: ☐ Yes ☐ No Chiropractor's Name/Location ____

Authorization of Release

In consideration of your undertaking to care for me, I agree to the following:

Triangle Chiropractic and Rehabilitation Center, PLLC, and its physicians and staff are authorized to release **any information** deemed appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me. I understand that TriangleCRC does not bill insurance companies directly, but I authorize the release of my information should I choose to seek reimbursement.

I acknowledge that my health-related information may be shared with other providers for my benefit and fully authorize TriangleCRC and its physicians and staff to **release and/or be the recipient of** information as necessary; this includes, but is not limited to: diagnostic imaging, patient records, procedures, surgical reports, and/or any pertinent health-related information.

Patient Signature:___________________________________ **Date:**_____/______/___________

Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

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Are you pregnant? ☐ Yes ☐ No # Weeks _________ Estimated Due Date: _________________ # of Pregnancies _______
# of Vaginal Births ______ # of Cesarean Births ______ Names and Ages of Children ____________________________________
Brief Birth History
____
____
____

If pregnant: Birth Team
Midwife: ______________________OB/GYN: ______________________________
Doula:____________________________ Other: __________________________
Where will you be birthing your baby?
Hospital_______ Home_______ Birthing Center________ Other___________
Have you taken, or do you plan to take, any childbirth education classes?
____

Are you less than two years postpartum? ☐ Yes ☐ No
Your postpartum recovery: ☐ Has been amazing. ☐ Is a work in progress. ☐ Needs improvement. ☐ I've had none.

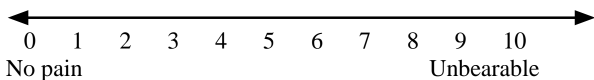
Please fill out the symptom chart below, OR select one of the following reasons for your visit:
☐ Pregnancy Care ☐ Diastasis Rectus Abdominis ☐ Pelvic Floor Dysfunction ☐ Wellness

If you are experiencing pain:
Present complaint(s):____
When did your symptoms begin? (Specific date if possible) ______________________________________
How did your symptoms begin? (i.e. Lifting, etc.) ____
In the past have you had anything similar to this? ☐ Yes ☐ No Please explain___________________________
____

DESCRIBE YOUR SYMPTOMS

#1 Complaint ______________________

(Rate your level of Pain, Scale 0-10)

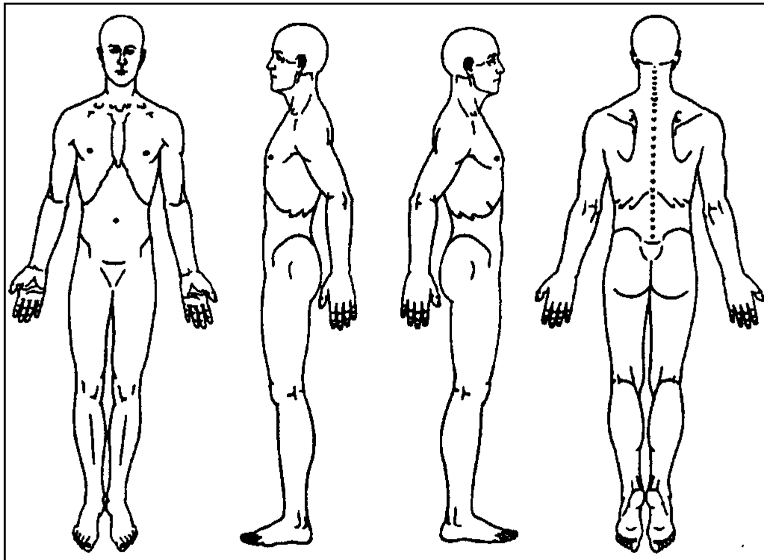


Check all that apply to your #1 Complaint

☐ Sharp ☐ Ache ☐ Tingling
☐ Stabbing ☐ Soreness ☐ Numbness
☐ Burning ☐ Weakness ☐ Dull
☐ Shooting ☐ Throbbing ☐ Constricting

☐ Other________________________________

How often are your complaints present?
☐ Constant 100% of the time ☐ Frequently 75%
☐ Intermittent 50% ☐ Occasional 25%



Are your symptoms:	Symptoms began:	Pain is aggravated by:	Pain is improved by:
☐ Increasing ☐ Decreasing ☐ Not Changing ☐ Varies	☐ Suddenly ☐ Gradually **Symptoms present:** ☐ AM ☐ PM ☐ All day	☐ Walking ☐ Lifting ☐ Sitting ☐ Bending ☐ Riding in a car ☐ Stretching ☐ Standing ☐ Twisting ☐ Other____________________	☐ Medication ☐ Chiropractic Adjustment ☐ Rest ☐ Ice ☐ Exercise ☐ Heat ☐ Therapy ☐ Nothing so far ☐ Other_____________________________

____
____
____
____

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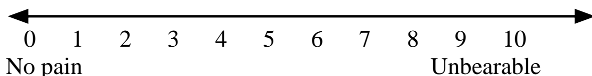
DESCRIBE YOUR SYMPTOMS

#2 Complaint ________________________

(Rate your level of Pain, Scale 0-10)



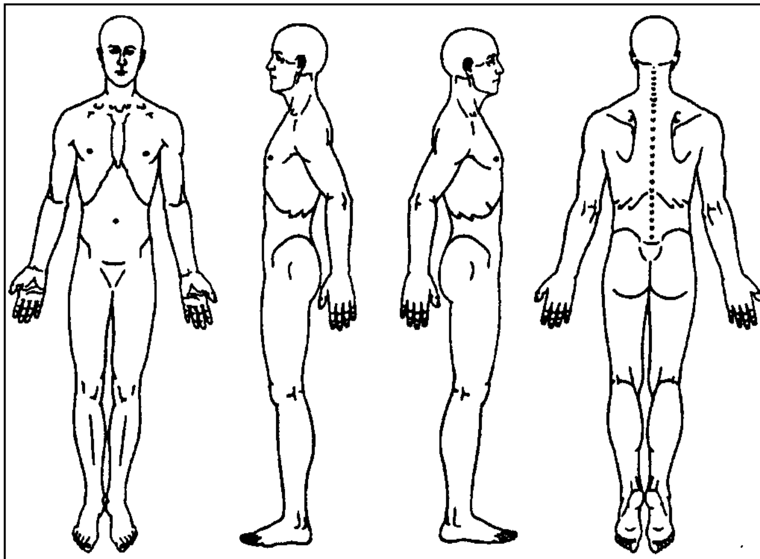
0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

Check all that apply to your #2 Complaint

☐ Sharp ☐ Ache ☐ Tingling
☐ Stabbing ☐ Soreness ☐ Numbness
☐ Burning ☐ Weakness ☐ Dull
☐ Shooting ☐ Throbbing ☐ Constricting

☐ Other_________________________________

How often are your complaints present?
☐ Constant 100% of the time ☐ Frequently 75%
☐ Intermittent 50% ☐ Occasional 25%



Are your symptoms:
☐ Increasing
☐ Decreasing
☐ Not Changing
☐ Varies

Symptoms began:
☐ Suddenly
☐ Gradually

Symptoms present:
☐ AM
☐ PM
☐ All day

Pain is aggravated by:
☐ Walking ☐ Lifting
☐ Sitting ☐ Bending
☐ Riding in a car ☐ Stretching
☐ Standing ☐ Twisting
☐ Other_____________________

Pain is improved by:
☐ Medication ☐ Chiropractic Adjustment
☐ Rest ☐ Ice
☐ Exercise ☐ Heat
☐ Therapy ☐ Nothing so far
☐ Other_______________________________

☐ Yes ☐ No Is pain affecting your ability to work or be active? If Yes explain:____

☐ Yes ☐ No Any change in bowel/bladder function, including stress incontinence? If Yes explain:________________________________

☐ Yes ☐ No Any fever or chills? If Yes explain:____

☐ Yes ☐ No Any dizziness associated with symptoms? If Yes explain:____

☐ Yes ☐ No Have you experienced any unexplained weight loss, fatigue, or blood loss? If Yes explain:___________________________

☐ Yes ☐ No Are your complaints affecting your sleep? If Yes explain:____

☐ Yes ☐ No Have you had any tests for this complaint? (i.e. x-rays, MRI, CT) If Yes explain:_______________________________________

☐ Yes ☐ No Any recent falls / accidents / surgeries / broken bones? If Yes explain:____

☐ Yes ☐ No Have you seen any other physicians in the past 6 months? If Yes explain:____

☐ Yes ☐ No Have you had any prior treatment, including any physical therapy? If Yes, what treatment?_______________________________

☐ Yes ☐ No Have you been in the hospital or had surgery for any reason? If Yes explain:____

☐ Yes ☐ No Have you ever been in an accident? If Yes explain:____

What **non-prescription** medication are you taking?

☐ Tylenol ☐ Aspirin
☐ Ibuprofen ☐ None
☐ Other__________________

How often?
☐Daily ☐Weekly ☐Other:___________

What **Prescription** medication are you taking?

☐ Anti-inflammatory ☐ Birth Control Pill ☐ Nerve Pills
☐ Pain Killers ☐ Cholesterol Meds ☐ HRT
☐ Muscle Relaxers ☐ Insulin ☐ Sleeping Aid
☐ Blood Pressure Meds ☐ Thyroid Meds ☐ Recent Antibiotics

☐ Other____ ☐ None
Specific names if possible:____

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☐ Yes ☐ No Do you smoke? If Yes how much?:____

If you have quit smoking, when did you quit?____

☐ Yes ☐ No Do you consume alcohol more than socially?

☐ Yes ☐ No Do you exercise? If Yes what is your routine?____

Do you experience any of the following:

☐ Stress urinary incontinence
☐ Urge incontinence
☐ Overactive bladder
☐ Bowel Incontinence
☐ Hemorrhoids
☐ Lack of orgasm
☐ Painful intercourse

If the answer to any of the following questions is yes, please elaborate as you feel comfortable. We will discuss these topics, and you need not fill out information that you do not wish to divulge.

Have you ever experienced sexual trauma or been the victim of sexual abuse? ______________________________

Have you experienced a miscarriage, infant loss, or abortion? ______________________________

Please circle regular dietary intake: fruits vegetables meats grains dairy products nuts/seeds/berries sugars Paleo/Primal gluten-free vegetarian Vegan

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below:

☐ Childhood Trauma
☐ Loss of loved one
☐ Abuse
☐ Divorce/Separation
☐ Financial stress
☐ Work/School stress
☐ Significant illness
☐ Major lifestyle change

How do you grade your physical health? (A= Great, B= Good, C= Needs Improvement, D= Nowhere to Go But Up)

☐ A
☐ B
☐ C
☐ D

How do you grade your emotional health?

☐ A
☐ B
☐ C
☐ D

How do you rate your overall “quality of life”?

☐ A
☐ B
☐ C
☐ D

Who else is on your healthcare team? Would you like us to keep in touch with them regarding your care? ☐ Yes ☐ No
____

What type of care are you interested in: ☐ Pain relief only ☐ Healing of current condition ☐ Optimizing your health ☐ All three

Pertinent family health history: list any diseases, disorders, or major illnesses ______________________________
____

Other health concerns?____