ORACLE SPINE AND ORTHOPEDICS

Dr. Michael C. Weiss, DO, FAOAO

Patient Name: _____ Date :_____ ID #: _____

Symptoms

Reason for visit

_____

_____

When did you first notice the symptoms?

_____

_____

How did this complaint began? _____

Is this condition getting progressively worse? _____

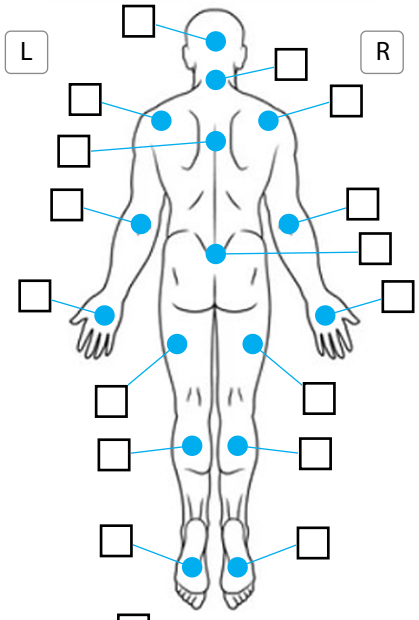
Where specifically is the problem(s) located?

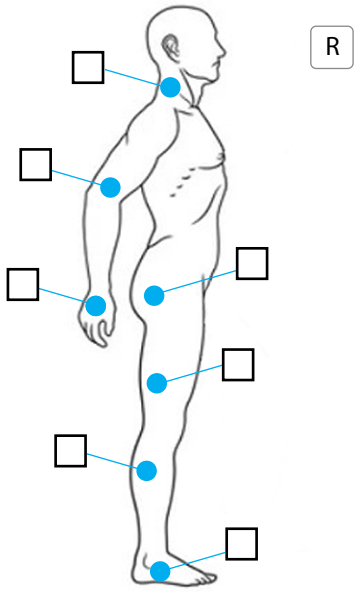
_____

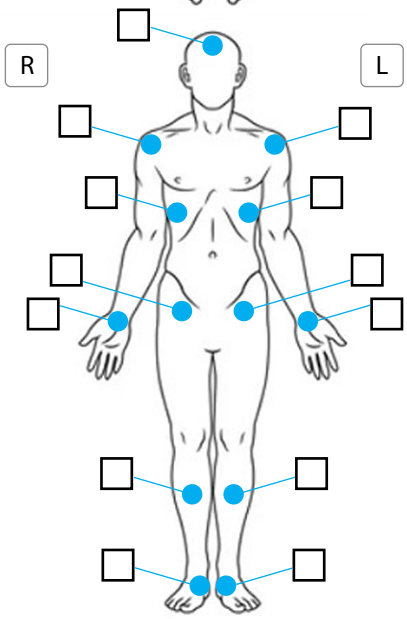
Which activities are difficult to perform? ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying down ☐Other

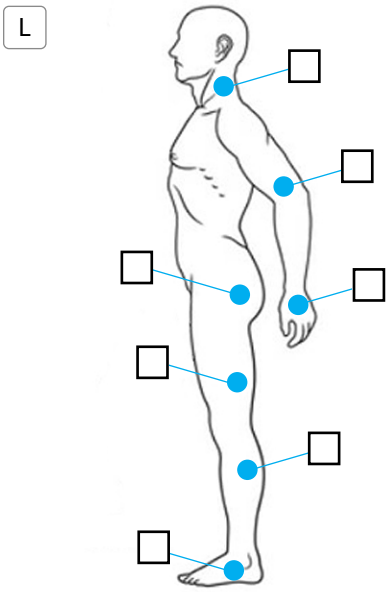
Type of Pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other

Please mark all areas where you feel symptoms.









ORACLE
SPINE AND ORTHOPEDICS

Dr. Michael C. Weiss, DO, FAOAO

Patient Name: _____ Date :_____ ID #: _____

Rate of severity of your pain (1, mild pain or discomfort, to 10 severe pain): 1

Is the pain constant or does it come and go? _____

Does anything aggravate the complaint? _____

Does anything make it better? _____

Previous illnesses you've had in your life? _____

Previous injury or trauma? _____

Have you ever received Chiropractic Care? ☐ Yes ☐ No If yes, where? _____

What treatment have you already received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ other _____

Name and address of other doctor(s) who have treated for your condition:

_____

_____

Date of Last Exams: _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

List any types of surgeries which you have had and the dates which they occurred:

_____

_____

Please list all medications you are currently taking:

_____

Allergies: _____

Family Health History:

Associated health problems of relatives

_____

Daily Habits

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor,

computer work) _____

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

Do you smoke? ☐ No ☐ Yes How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Authorization

The patient agrees to comply with OFFICE POLICY which includes all responsibility for payment for services provided in this office for my self or my dependents is mine, due and payable at the time services are rendered unless other arrangements are made in advance. In the event payments are not received by the agreed upon dates, I understand that 1 ½ % finance charge (18%) APR may be added to my account. I agree to pay an attorney and collection fees if this account is turned over for collection. X-rays remain the property of this clinic. Data from patient's treatments (excluding patient's names) may be used for research purpose.

_____ _____

SIGNATURE OF PATIENT (or parent if a minor) *Date* *SIGNATURE OF DOCTOR* *Date*

By entering your name, you are signing this document *By entering your name, you are signing this document*