Welcome to Patriot Chiropractic Date:_____

Name:_____ DOB:_____ Age:_____ Primary Language:_____

Address:_____Apt#____ City:_____State:____Zip:_____

Cell Phone:_____ HomePhone:_____ Social Sec.#:_____-____-_____

Email address:_____

Status:☐Single, ☐Married, ☐Divorced, ☐Widowed Sex: ☐M ☐F

Your Employer:_____ Occupation:_____

In case of an emergency please notify:_____Phone:_____

Please Let Us Know Who Referred You- ☐Facebook ☐Yelp ☐Website ☐Google ☐Phone Book ☐Insurance ☐Midwife ☐Ob/Gyn ☐Friend/ Family ☐Current Patient ☐Doctor ☐Attorney ☐Other_____

ASSIGNMENT & RELEASE OF LIABILITY

I, the undersigned, certify that I, and/or my dependent(s), assign directly to Dr. Athanasia Angelopoulos, DC, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this office immediately whenever I have changes in my health condition or health plan coverage in the future.

X_____INITIAL

CONSENT TO CHIROPRACTIC ADJUSTMENTS AND TREATMENT

I understand that Patriot Chiropractic is owned and operated by Dr. Athanasia Angelopoulos. I acknowledge that during the course of my care I (or the person named below for whom I am legally responsible) may receive chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, massage and diagnostic x-rays by Dr. Athanasia Angelopoulos. I understand that, as the practice of medicine, in the practice of other clinical therapies there are some risks to treatment. I understand that if I receive chiropractic treatments the most common risks are temporary aggravation of my condition/soreness or bruising. Rarer risks include, but are not limited to, fractures, strokes, dislocation, sprains, burns and aggravation of disc injuries. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on him or her to exercise judgment during the course of the procedure which he or she feels at the time, based on the facts then known, is in my best interests. I have read, or have read to me, the above consent. By signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

X_____INITIAL

NOTICE OF PRIVACY PRACTICES

I have read the Notice of Privacy Practices that was provided to me. I understand that I have the right to a paper copy of this policy at any time upon request. If I have any questions, I may contact Dr. Athanasia Angelopoulos at 502-352-7171.

X_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

CONSENT TO TREATMENT OF MINOR

I hereby authorize Dr. Athanasia Angelopoulos D.C. to administer treatment as they deem necessary to my son/ daughter.

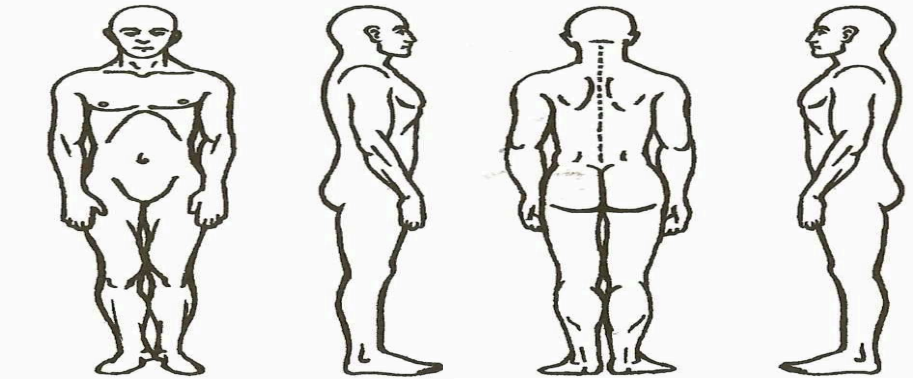
X_____ _____

Signature of Parent, Guardian or Personal Representative Date

On the figures to the right, please indicate where you have symptoms.
Use the following key:

PAIN = XXX

NUMBNESS or TINGLING =!!!



How long have you had your symptoms?_____

Have you ever had symptoms in this area before, if so, when?_____

Describe how your pain began:_____

My symptoms are made worse by: (OK to check more than one) ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lifting ☐Sleeping ☐Twisting/Turning ☐Physical Activity ☐Not changing

My symptoms are relieved by:_____

List All Surgeries and Age/ Year:

_____

_____

_____

Family History: ☐ High Blood Pressure ☐ Cancer ☐ Rheumatoid Arthritis ☐ Stroke ☐ Diabetes ☐ Heart Problems

List All Medications:

_____

_____

_____

List All Allergies: _____

Recent accidents/ Injuries? ☐Yes ☐N

Do you have a pacemaker or defibrillator? ☐Yes ☐N

Have you ever had any of the following: cancer, aneurysm, heart problem, broken a bone or any part of your spine? ☐Yes ☐N

Have you experienced any rapid weight loss/gain recently? ☐Yes ☐N

* Please check the box if you have ever had/ have the condition.

General:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Cancer
- ☐ High cholesterol
- ☐ Skin Problems
- ☐ Thyroid problems
- ☐ Gout
- ☐ Rheumatic fever
- ☐ Rheumatoid arthritis
- ☐ Polio
- ☐ Multiple sclerosis
- ☐ Depression
- ☐ Frequent influenza
- ☐ Osteoarthritis

Nervous System:
- ☐ Dizziness/Lightheaded
- ☐ Fainting
- ☐ Discoordination
- ☐ Memory loss

Eye, Ear, Nose and Throat:
- ☐ Vision disturbances
- ☐ Hearing loss
- ☐ Ear pain
- ☐ Ear noises
- ☐ Dental problems
- ☐ Frequent sinus trouble
- ☐ Difficult speech

Blood Sugar:
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Get “shaky” if hungry
- ☐ “Lightheaded” if meals delayed
- ☐ Fatigue relieved by eating
- ☐ Excessive thirst
- ☐ Irritable before meals
- ☐ Heart palpitates w/skipped meals

Cardiovascular:
- ☐ Pain over heart
- ☐ Irregular heartbeat
- ☐ Low blood pressure
- ☐ Heart attack

☐ Hepatitis- type/s_____
☐ HIV
☐ Parkinson's disease
☐ Epilepsy/Seizures

Gastrointestinal:
☐ Hiatal hernia
☐ Metallic taste in mouth
☐ Burning in stomach relieved by eating
☐ Distress from greasy food
☐ Blood in stool
☐ Gall bladder problem
☐ Heartburn
☐ Ulcers
☐ Liver trouble
☐ Frequent Nausea/Vomiting
☐ Colitis
☐ Frequent Constipation
☐ Frequent Diarrhea

Urinary Tract:
☐ Kidney stones
☐ Current kidney/bladder infection
☐ Blood in urine
☐ Inability to control urination
☐ Painful urination

Respiratory:
☐ Chest pain
☐ Chronic cough
☐ Coughing up blood
☐ Tuberculosis
☐ Difficulty breathing
☐ Emphysema/ COPD
☐ Shortness of breath
☐ Asthma
☐ Pneumonia

☐ Stroke
☐ High blood pressure
☐ Swelling in ankles
☐ Shortness of breath on exertion
☐ Pressure over chest

Men Only:
☐ Prostate trouble

Women Only:
☐ Excessive flow
☐ Irregular periods
☐ Hot flashes
☐ Lumps in breasts
☐ Painful breasts
☐ Are you Pregnant? ☐Yes ☐No
☐ Hysterectomy

Do you use tobacco products? ☐Yes ☐N How long?_____ What type?_____

Have you had X-Rays / MRI / CT Scan of the problem area within the last 12 months? ☐ Yes ☐ No

Who is your primary care physician?_____

What treatment have you already received for this condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐Other_____ ☐ None

Is this condition due to an accident? ☐ Yes ☐ No Type of Accident: ☐ Auto ☐ Work ☐ Other

Have you ever been adjusted by a chiropractor? ☐ Yes ☐ No How long ago?_____

Daily Living Impact- Please describe how you have been impacted by your symptoms.

Work:
What is your primary function at work?_____
Do you ever need to ask for help? ☐ Yes ☐ No
Are there any parts of your job you find yourself shying away from?_____
Have you ever had to miss work? ☐ Yes ☐ No How many days?_____

Household Chores/ Yard Work:
Are there any chores you are now avoiding/ shying away from? ☐ Yes ☐ No If yes, please list:_____
Do you have to take more breaks to complete your chores? ☐ Yes ☐ No
Have you had to ask family members/ friends to assist with chores? ☐ Yes ☐ No

Recreational Activities/ Exercise:
What recreational activities/exercises are you involved in?_____
Are there any activities you find yourself shying away from? ☐ Yes ☐ No If yes, please list _____

Relationships:
What activities or things do you usually do with your Spouse, Children/ Friends?_____
Have you been avoiding going out with friends or family because of your pain? ☐ Yes ☐ No
Do you find yourself avoiding playing with/ holding children or grandchildren? ☐ Yes ☐ No
Do you think your spouse or family might say you have been less patient than usual? ☐ Yes ☐ No
Are there any other areas of your life affected by this condition? ☐ Yes ☐ No If yes, please list _____

How much do your symptoms interfere with your daily activities?
☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely