Bellevue Center for Wellness and Hyperbaric
Oxygen Therapy Kirk W. Jones, D.C.
Confidential Patient Information

REFERRED BY: □ Insurance Co., □ Internet, □ Other: _____ (Please check)

NAME: _____ **DATE**: _____
BIRTH DATE _____/_____/_____ AGE: _____ SOCIAL SECURITY # _____
CURRENT ADDRESS: _____ **APT #** _____
CITY: _____ **ST**: _____ **ZIP**: _____
PHONE: Cell ( ) _____ Home ( ) _____ Work ( ) _____
EMAIL ADDRESS: _____
Employer Name: _____ City/State/Zip: _____
Occupation: _____ Emergency Contact/Phone: _____
Name of Spouse: _____ Spouse Birth Date: _____ Spouse Phone: ( ) _____

HEALTH INFORMATION

Chief Complaint: _____
Nature of occurrence: _____
How long have you had this condition? _____
Did your pain come on suddenly or slowly? _____
Have you had similar conditions in the past? _____ If yes When_____
Does this condition affect your work? Yes/No Does this condition affect your family or social life? Yes/No
Do you do repetitive motions while at work or when working on a hobby? Yes/No
Do you continually hold your arms above your head while at work? Yes/No
Is your pain worse with certain movements? Yes/No
What aggravates this condition? _____
What treatments have you tried for your pain? _____
Have you had any surgery, falls or accidents: Yes/No When? _____
Please describe_____
Date of last physical examination: _____ Date of last spinal x-ray_____
Have you had previous chiropractic care? Yes/ No When _____ Where _____
Primary Care Physician: _____ Phone: ( ) _____
Number of children and ages: _____ Number of pregnancies: _____
Known Allergies: _____ Medications: _____

CURRENT MEDICAL COMPLAINTS

Do you experience pain every day? □Yes □No Does your pain wake you up during the night? □Yes □ No
Does your pain worsen during menses? □Yes □No Are you able to work with your pain? □Yes □ No

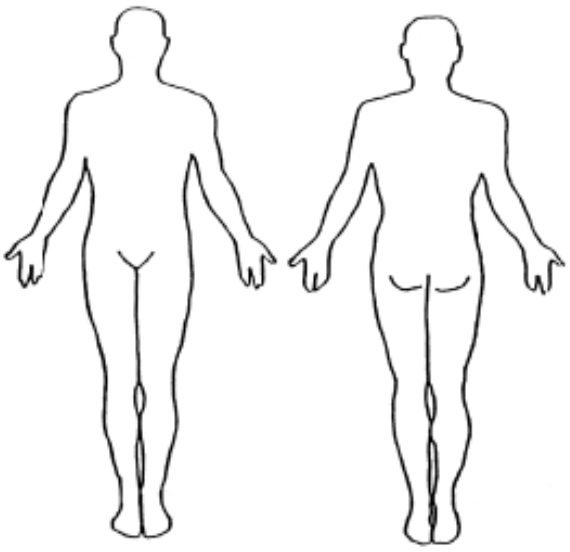
Presently pain is increased when you: **Sit?** □Yes □No **Climb?** □Yes □No **Stand?** □Yes □No
Crouch? □Yes □No **Rise from the chair?** □Yes □No **Kneel?** □Yes □No **Walk?** □Yes □No
Bend? □Yes □No **Push?** □Yes □No **Pull?** □Yes □No **Rise up from bending?** □Yes □No
Lift? □Yes □No **Crawl?** □Yes □No **Repeated lifting?** □Yes □No **Traveling and or driving** □Yes □No
Reach <u>above</u> shoulder level? □Yes □No **Reach <u>below</u> shoulder level?** □Yes □No

What do you do to relieve the pain? _____
If you have been treated by others for this condition, please list in order of most recent:
1) _____ Date: _____ City: _____
2) _____ Date: _____ City: _____
3) _____ Date: _____ City: _____

During the past two months has your condition: □ Improved □ Unchanged □ Worsened
Describe how your condition affects at-home responsibilities, recreational activities and lifestyle:
_____
Do you perform daily neck/back exercises: □Yes □ No

INSURANCE INFORMATION

Medical Insurance Co.: _____ ID #: _____ Group #: _____
Is this condition due to: A work injury □Yes □No - An automobile accident □Yes □ No



Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing:

SHARP AND STABBING ††††
DULL AND ACHY **XXXX**
PINS AND NEEDLES **0000**
NUMBNESS //////

Is your pain constant: □ Yes □ No. If No how many times per day? _____
Severity of your pain on a scale of 1-10 1 2 3 4 5 6 7 8 9 10
Is pain radiating □ Yes □ No To where _____
Is there a time of day the pain is worse? _____
Please describe other medical complaints:
_____
_____
_____
_____

DO YOU SUFFER FROM:	YES / NO		DO YOU SUFFER FROM:	YES / NO	
Headache	❑	❑	Lung or Bronchial Disorder	❑	❑
Neck Pain	❑	❑	Digestive Disorder	❑	❑
Arm/Shoulder Pain	❑	❑	Constipation	❑	❑
Back Pain	❑	❑	Loose Stool	❑	❑
Hip or Leg Pain	❑	❑	Diabetes	❑	❑
Chest Pain	❑	❑	Swollen Joints	❑	❑
Abdominal Pain	❑	❑	Insomnia	❑	❑
Sinus Trouble	❑	❑	Dizziness	❑	❑
Heart Trouble	❑	❑	Numbness	❑	❑
Palpitation	❑	❑	Nervousness or Stress	❑	❑
Circulatory	❑	❑	Depression	❑	❑
High or Low Blood Pressure (Circle which)	❑	❑	General Fatigue	❑	❑
Female Problems	❑	❑	Morning Fatigue	❑	❑
Osteoporosis	❑	❑	Rheumatoid Arthritis	❑	❑
Prostate Disorder	❑	❑	Anemia	❑	❑
Kidney Problems	❑	❑	Poor Memory	❑	❑
Bladder Problems	❑	❑	Nausea	❑	❑
Cancer	❑	❑	Problems with balance	❑	❑
Scoliosis	❑	❑	Weakness or heaviness in arms or legs	❑	❑

I understand I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. I hereby assign my major medical insurance benefits, including Medicare, private insurance and other health plans to Bellevue Center for Wellness and Hyperbaric Oxygen Therapy. Any overpayment will be promptly refunded. I also authorize Bellevue Chiropractic Center to release any information required to secure payment. If balance becomes delinquent and suit is filed, I agree to pay all collection costs, court costs, and attorney's fees in addition to the above fee. Accounts over 90 days delinquent may be subject to a monthly billing fee of $10.00.

Patient/Guardian Signature _____ Date _____

121 Belle Forest Circle, Nashville, TN 37221-2157
(615) 662-0001 – Fax: (615) 662-0000