Dr. Paul Sayour and Dr. Michael Preneta
Wickford Chiropractic and Wellness Center

UPDATE PATIENT FORM FOR CONFIDENTIALCASE HISTORY FILE. PATIENT/MEDICAL INFORMATION IS USED FOR TREATMENT, REFERRAL AND CLAIMS PROCESSING ONLY.

DATE: _____

FULL NAME_____AGE_____DATE OF BIRTH_____SS#:_____

ADDRESS_____CITY_____STATE_____ZIP_____

EMAIL ADDRESS:_____

HOME PHONE_____WORK PHONE_____CELL PHONE_____

HEIGHT_____WEIGHT_____ MARITAL STATUS: M W D S GENDER: M F OTHER

EMPLOYMENT Status *(check one)* ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

OCCUPATION_____EMPLOYER_____ADDRESS_____

SPOUSE'S NAME_____OCCUPATION_____SPOUSE'SEMPLOYER_____ADDRESS_____

RACE *(CHECK ONE)* ❑ WHITE ❑ BLACK/AFRICAN AMERICAN ❑ HISPANIC ❑ AMERICAN INDIAN/ALASKAN NATIVE

❑ ASIA ❑ ASIAN INDIAN ❑ CHINESE ❑ FILIPINO ❑ JAPANESE ❑ KOREAN ❑ VIETNAMESE ❑ SAMOAN

❑ NATIVE HAWAIIAN OR OTHER PACIFIC ISLAND ❑ GUAMANIAN OR CHAMORRO ❑ OTHER_____ _____

❑ I CHOOSE NOT TO SPECIFY **MULTI-RACIAL** *(CHECK ONE)* ❑YES ❑NO ❑ UNKNOWN

ETHNICITY *(CHECK ONE)* ❑ HISPANIC OR LATINO ❑ NOT HISPANIC OR LATINO ❑I CHOOSE NOT TO SPECIFY

PREFERRED LANGUAGE *(CHECK ONE)* ❑ ENGLISH ❑ SPANISH ❑ AMERICAN SIGN LANGUAGE ❑ CHINESE ❑ FRENCH

❑ GERMAN ❑ TAGALOG ❑ VIETNAMESE ❑ ITALIAN ❑ KOREA N❑ RUSSIAN ❑ POLISH ❑ ARABIC

❑ PORTUGUESE ❑ JAPANESE ❑ FRENCH CREOLE ❑ GREEK ❑ HINDI ❑ PERSIAN ❑ URDU ❑ GUJARATI ❑ ARMENIAN

❑ I CHOOSE NOT TO SPECIFY

INSURED'S NAME_____ RELATIONSHIP TO PATIENT _____

INSURED'S DATE OF BIRTH _____ **INSURED'S** SOCIAL SECURITY #_____

INSURED'S ADDRESS _____PHONE_____

NEAREST RELATIVE OR FRIEND TO CALL IN CASE OF EMERGENCY:_____

ADDRESS:_____HOME PHONE:_____CELL #:_____

REFFERED BY _____

PRIMARY CARE PHYSICIAN _____ADDRESS/PHONE #_____

IS THIS A WORKER'S COMPENSATIONS INJURY: YES_____ NO_____ AUTO ACCIDENT YES_____ NO_____

WORKERS COMPENSATION/AUTO INSURANCE CARRIER_____ADJUSTER:_____

CONTACT INFORMATAION: PHONE_____CLAIM #:_____

Name_____**DOB:**_____**Date**_____

Your Health History: Please fill out completely:

ANY CHANGES MUST BE NOTED. IF NO CHANGES INDICATE "NONE"

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

Smoke per day?_____

If yes, what is your level of interest in quitting smoking? ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9❑10very

How much do you: Drink per week? _____

List major illness and dates:_____

_____

Current medications, including frequency and dosage if known. There are **NO** current medications, check here❑

1) _____ 2) _____

3) _____ 4) _____

List vitamins and supplements:

_____

List any known allergies you have had to any medications or any know allergies.
If no allergies are known, check here: ❑

1) _____ 2) _____

List surgeries & dates:_____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe:_____

Has any doctor diagnosed you with Diabetes presently?❑ Yes ❑ No If yes, what kind? ❑ Type I❑Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Family History: relationship (mother, father, etc.)_____

Cancer_____ Diabetes_____Heart_____Stroke_____

What exercise do you do? ☐ Power walking ☐ Jogging ☐ Spin Cycling ☐ Swimming ☐ Yoga

☐ Pilates ☐ Weight training ☐ Zumba ☐ Other_____

Are you having any trouble whatsoever controlling your bowel and/or bladder function? ☐Yes ☐ No

Have you treated with another physician for your current symptoms? YES: Dr. _____

Are you having any trouble whatsoever controlling your bowel and/or bladder function? ☐Yes ☐ No

Have you treated with another physician for your current symptoms? YES: Dr. _____

Name_____**DOB:**_____**Date**_____

Please describe ONE complaint per page

CHIEF COMPLAINT #1: (Indicate here) _____

Pain/Symptom Intensity : Mild

0	1	2	3	4	5	6	7	8	9	10

Severe

Mechanism of Injury: ☐ Lifting ☐ Falling ☐ Work Accident ☐Repetitive Motion ☐ Other_____

Injury Date: ___/___/____ **Onset Date:** ___/___/____ **Complaint present for**: _____ Day(s)/ Month(s)/ Year(s)

Frequency: Your complaint is present _____% of the ☐ Day ☐ Month ☐ Year

Timing: Your complaint is worse: ☐ Morning ☐ Midday ☐ Evenings ☐ Night

Your complaint is better: ☐ Morning ☐ Midday ☐ Evenings ☐ Night

Radiating Down: ☐ Left ☐ Right ☐ Both

☐ Shoulder ☐ Upper Arm ☐ Arm ☐ Arm to Hand ☐ Buttock ☐Upper leg ☐ Leg ☐ Calf ☐ Foot

Quality: Circle all that apply

Dull	Sharp	Throbbing	Burning	Deep	Aching
Tingling	Stabbing	Cramping	Numbness	Radiating	Other

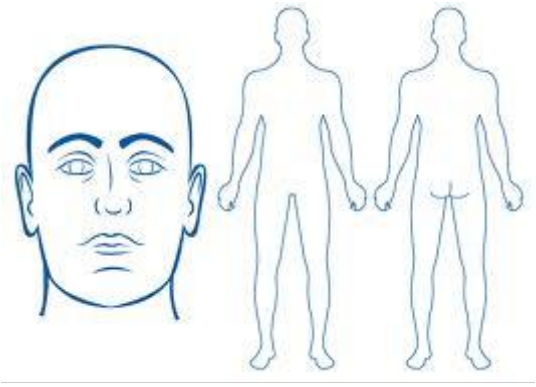
Aggravating factors: Circle all that apply

Sitting	Standing	Walking	Bending	Stooping	Lifting
Sleeping	Sneezing	Coughing	Straining	Reaching	Twisting
Looking up	Looking down	Movement	Rest	Lying supine	Driving
Typing	Scooping	House chores	Exercise	Lying prone	Stair stepping

Relieving factors: Circle all that apply:

Sitting	Standing	Lying	Knees bent	Support
No movement	Movement	Heat	Ice	Analgesic topical
Ibuprofen	Medication	Rest	Stretching/Exercise	Adjustments

Place an "X" on all areas related to this complaint



Name_____DOB:_____Date_____

Were x-rays taken? Other diagnostics test?

Yes:_____Date:_____Facility:_____

Please check all that apply:

☐ Sleeping Problems	☐ Diarrhea	☐ Kidney Problems	☐ Foot Pain
☐ Nervousness	☐ Constipation	☐ Bladder Problems	☐ Foot Numbness
☐ Stress	☐ Vomiting	☐ Hyperthyroid	☐ Arm Pain
☐ Irritability	☐ Stomach Ulcers	☐ Hypothyroid	☐ Arm Numbness
☐ Fatigue	☐ Acid Reflux	☐ Tonsils/Adenoids	☐ Hand Numbness
☐ Depression	☐ Psoriasis	☐ Diabetes	☐ Finger Numbness
☐ Memory Loss	☐ Eczema/Rashes	☐ Hyperglycemia	☐ Sciatica
☐ Chest Pains	☐ Shingles	☐ Hypoglycemia	☐ Shoulder Pain
☐ ↑ Blood Pressure	☐ Ear Infections	☐ Tension Headaches	☐ Blurred Vision
☐ ↓Blood Pressure	☐ Frequent Colds/Flu	☐ Sinus Headaches	☐ Hormone Problems
☐ Allergies/Asthma	☐ Fever	☐ Migraines	☐ HIV Positive
☐ Shortness of Breath	☐ Infertility	☐ Neck Pain/ Stiffness	☐ History of Cancer
☐ Ears Ring/ Buzz	☐ Menstrual Problems	☐ Mid-Back Pain	☐ History of Heart Disease
☐ Dizziness / Vertigo	☐ Vaginal Infections	☐ Low Back Pain	☐ Fainting Spells
☐ Prostate Problems	☐ Gall Bladder Problems	☐ Pinched Nerve	☐ Liver Problems
☐ Cold Sweats	☐ Loss of Smell / Taste	☐ Herniated Disc	☐ Leg pain
☐ Intestinal Problems			☐ Leg Numbness

A PATIENT COMING TO THE DOCTOR GIVES HIM/HER PERMISSION AND AUTHORITY TO CARE FOR THE PATIENT IN ACCORDANCE WITH THE APPROPRIATE TESTS, DIAGNOSIS, ANALYSIS, AND TREATMENT. THE DOCTOR, OF COURSE, WILL NOT PROVIDE SPECIFIC HEALTHCARE, IF HE/SHE IS AWARE THAT SUCH TREATMENT MAY BE CONTRA-INDICATED.

☐ **SIGNING THIS FORM GIVES THIS OFFICE PERMISSION TO LEAVE MESSAGES ON THE PATIENT'S HOME PHONE AND/OR CELL PHONE. PLEASE NOTIFY THE OFFICE IF OTHER ARRANGEMENTS NEED TO BE MADE.**

☐ **I HEREBY AUTHORIZE PAUL E. SAYOUR, DC TO SUBMIT A CLAIM TO MY INSURANCE CARRIER(S) AND DIRECT MY INSURANCE CARRIER TO ISSUE PAYMENT CHECKS DIRECTLY TO: PAUL E. SAYOUR, DC.**

☐ **I AUTHORIZE THE REQUEST AND RELEASE OF MEDICAL INFORMATION/TESTING/IMAGING.**

☐ **I ACKNOWLEDGE WICKFORD CHIROPRACTIC'S NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION. PATIENT CAN CHANGE AUTHORIZATION/UNAUTHORIZED STATUS AT ANYTIME.**

PAYMENT IS EXPECTED AT THE TIME OF VISIT.

WE ACCEPT CREDIT CARDS, PERSONAL CHECKS, AND CASH. IT IS OUR CUSTOMARY PROCEDURE TO PROMPTLY FILE INSURANCE CLAIMS. THE PATIENT PAYS ANY DEDUCTIBLES, CO-PAYMENTS, UNCOVERED, REJECTED, DENIED OR OTHERWISE UNPAYABLE CLAIMS.

PATIENT'S SIGNATURE _____