WELCOME

Liringis Chiropractic

Winston-Salem (336) 768-1004 • Fax (336) 659-1373
3570 Vest Mill Road, #B • Winston-Salem, NC 27103

Greensboro (336) 299-3230 • Fax (336) 299-2122
1622 Stanley Road • Greensboro, NC 27407

Dr. Steve Liringis
Dr. LaTanya Bowman

1 ABOUT YOU

Today's Date: _________ / _________ / _________ File #: ______________________________

Patient Name: ____
LAST FIRST MI

What you prefer to be called: ____________________________________ ❏ Male ❏ Female

Birthdate: _________ / _________ / _________ Age: ________ SS#: ______________________

Mailing Address: ____

____
CITY STATE ZIP

Home Phone #: ______________________________ Cell Phone #: ______________________

Work Phone #: ______________________________ Ext: ______________________________

E-mail Address: ____

Employer: ____ How long? _________________

Employer's Address: ____

____
CITY STATE ZIP

Occupation: ____

Status: ❏ Minor ❏ Single ❏ Married ❏ Divorced ❏ Separated ❏ Widowed

Spouse's Name: ____

Do you have children? ❏ Yes ❏ No How many? ___________________

2 IN EVENT OF EMERGENCY

Whom should we contact? ____

Relation: ____

Home Phone #: ______________________________ Cell Phone #: ______________________

Work Phone #: ______________________________ Ext: ______________________________

Who is your medical doctor? ____

Medical doctor's phone #: ____

❯ **continue on next page**

3 REASON FOR VISIT

1. Reason for today's visit: ❑ New Injury ❑ Old Injury ❑ Wellness ❑ Chronic Pain
2. Are you in pain: ❑ Yes ❑ No

3. **In this section, check the <u>ONE</u> BOX which best describes <u>how your problem started</u>. Then answer the questions below the box you checked. Use as much space to the right as needed.**

ANSWER: COMMENTS

A. ❑ **Auto Accident** Date ______________________

1. How was your car hit? ______________________
2. Amount of damage to the vehicle you were in? (in dollars) ______________________
3. Did you know the accident was coming? ❑ Yes ❑ No ______________________
   If yes, check one of the blocks below:
   ❑ Aware of impending collision ______________________
   ❑ Unaware of impending collision ______________________
   ❑ Aware of impending collision and I braked ______________________
4. Did you lose consciousness during the accident? ❑ Yes ❑ No ______________________

B. ❑ **SPORT INJURY**
Date______________, Where and How did it happen? ______________________
What sport______________ ______________________

C. ❑ **INJURY AT WORK** Date______________,
From a ❑ Lift ❑ Twist ❑ Fall ❑ Bend ❑ Pull ❑ Reach ______________________

D. ❑ **WORK RELATED - (BUT <u>NO</u> INJURY)**
Date______________, How did your job cause this problem? ______________________

E. ❑ **WELLNESS CARE (NO ACCIDENT OR INJURY INVOLVED)** ______________________

4 HOSPITAL INFORMATION

1. Did you go to the hospital? ❑ Yes ❑ No Date you went there: ______________________
2. What was the name of the hospital? ______________________
3. How did you get to the hospital? ❑ Ambulance ❑ Police car ❑ Walked ❑ Helicopter ❑ Drove self ❑ Somebody else ❑ Other
4. Did you receive any stitches for any cuts at the hospital? ❑ Yes ❑ No
5. Were x-rays taken at the hospital? ❑ Yes ❑ No If yes, which area was taken?
   ❑ Neck ❑ Skull ❑ Mid back ❑ Lower back ❑ Pelvis ❑ Hips ❑ Leg ❑ Knee ❑ Foot ❑ Shoulder ❑ Arm ❑ Other
6. Were you hospitalized overnight? ❑ Yes ❑ No
7. Check what you were prescribed at the hospital: ❑ Pain medication ❑ Muscle relaxers ❑ Neck brace ❑ Other
8. Have you had any of these treatments?
   Injection ❑ Yes ❑ No Brace ❑ Yes ❑ No Physical Therapy ❑ Yes ❑ No Cane/Crutch ❑ Yes ❑ No
9. Did you have to go back to the hospital? ❑ Yes ❑ No
   If yes, name of hospital:______________________ Date you went there: ______________

5 OTHER MEDICAL PROVIDERS

1. Is Liringis Chiropractic the only doctor's office you have been to for this accident? ❑ Yes ❑ No
If no, what other doctor's office have you been to? ______________________
Date you went there: ______________________ Specialty: ______________________

2. Were x-rays done? ❑ Yes ❑ No If yes, which area was taken?
❑ Neck ❑ Skull ❑ Mid back ❑ Lower back ❑ Pelvis ❑ Hips ❑ Leg ❑ Knee ❑ Foot ❑ Shoulder ❑ Arm ❑ Other
If yes, name of place x-rays were taken: ______________________ Date x-rays were taken: ______________

3. Check what you were prescribed: ❑ Pain medication ❑ Muscle relaxers ❑ Neck brace ❑ Other

› **continue on next page**

6 WORK EXCUSE OR WORK LIMITATION

1. Before coming to Liringis Chiropractic did you miss any work? ❑ Yes ❑ No
If **yes**, please ask our staff for a calendar and list each date you missed. Also, list number of hours missed on each date.
Date/hrs.: ____

2. Has **any medical doctor** written you out of work? ❑ Yes ❑ No
If **yes**, please ask our staff for a calendar and list each date you were written out below. Also, list number of hours missed on each date.
Date/hrs.: ____

3. Has **any medical doctor** written you a **work limitation**? ❑ Yes ❑ No
If **yes**, please explain: ____

7 HEALTH HISTORY

1. **Do you have or have you had any of the following diseases, medical conditions or procedures?**

Y N Heart Attack/Stroke	**Y N** Heart Surgery/Pacemaker	**Y N** Heart Murmur	**Y N** Congenital Heart Defect	**Y N** Mitral Valve Prolapse
Y N Artificial Valves	**Y N** Alcohol/Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis	**Y N** HIV / AIDS / ARC
Y N Shingles	**Y N** Cancer	**Y N** Frequent Neck Pain	**Y N** Glaucoma	**Y N** Anemia/Diabetes
Y N Hi/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever	**Y N** Severe/Frequent Headaches	**Y N** Kidney Problems
Y N Ulcers/Colitis	**Y N** Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Emphysema/Asthma	**Y N** Tuberculosis
Y N Difficulty Breathing	**Y N** Chemotherapy	**Y N** Lower Back Problems	**Y N** Artificial Bones/Joints/Implants	**Y N** Arthritis

2. Please list any surgeries with dates and/or other serious medical condition(s) not listed above:
____
3. List any past serious accidents with dates: ____
4. Please list anything that you may be allergic to: ____
5. Family Health History: ____
6. Do you take supplements or vitamins? ❑ Yes ❑ No Do you exercise? ❑ Yes ❑ No ________ hours per week
7. Do you smoke? ❑ Yes ❑ No How much? ______________________ How long? ______________
8. Are you wearing: ❑ Shoe Lifts ❑ Inner Soles ❑ Arch Supports ❑ Are you dieting? ❑ No ❑ Yes Since:_____/_____/_____
9. For women: Are you taking birth control? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No
Are you pregnant? ❑ Yes ❑ No If so, how many weeks? ____________________

Patient name (print): ____ Date: __________________

Patient signature: ____

▲ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

▲ Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the business manager.

▲ I authorize the staff to perform any necessary services needed during diagnosis and treatment.

▲ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: ____ Date: ____________________