Comfort Chiropractic & Acupuncture

Dr. Linda Orlasky, D.C.
700 Exposition Place, Suite 141
Raleigh, NC 27615 (P) 919-872-1050 (F) 919-872-5025

CONFIDENTIAL PATIENT INFORMATION

Welcome to Comfort Chiropractic and Acupuncture! Please complete this form **Completely and Accurately**. Your answers will help us determine if Chiropractic, Acupuncture or Functional Medicine care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. If you should need help, please feel free to ask. This information will be held in the strictest confidence.

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Who referred you to Dr. Orlasky? ____

PATIENT INFORMATION

First Name: ______________________Last Name: ______________________ MI: ___SSN _______________

Address: ____City: ________________State: ____________

Zip Code: _______________Birth Date: _____________________Age: _______ Number of Children: _____

Marital Status ( ) M ( ) S ( ) W ( ) D Spouses Name______________ Spouses Hm orWk Phone: _____________

Your Employers Name: _____________________________________ Occupation: _____________________

Home Phone: ___________________Work Phone: ___________________ Cell Phone: __________________

Email address: ____

Emergency Contact Name: ___________________________________Their Phone: _____________________

PRESENT COMPLAINT

What are your symptoms? ____

____

How long have you had this condition? ______ Yrs. ______Mos. Have you had similar conditions in the past?
( ) Yes ( ) No If yes, please Explain: ____

____

Other Doctors Seen for this condition: ____

What caused your present condition? ____

What aggravates this condition? ____

Your condition is: ( ) getting progressively worse ( ) stay the same ( ) getting better ( ) constant pain ( ) comes and goes

Your condition interferes with your: ( ) work ( ) sleep ( ) daily routine ( ) other____________________________

Previous Chiropractic Care? ( ) Yes ( ) No If yes, when? _______________ For what condition: ______________

____

MEDICAL HISTORY

Have you been treated by any Doctor in the past year: ( ) Yes ( ) No
If yes what for? ____

Drugs you now take: ( ) Nerve pills ( ) Pain Killers ( ) Muscle relaxers ( ) Pep pills
( ) Tranquilizers ( ) Insulin ( ) Birth Control ( ) Blood Pressure ( ) Others: Please list

____

List any medication allergies ____

Do you smoke? ( ) Yes ( ) No _________ Packs per ( ) Day ( ) Week for _________
( ) Months ( ) Years

Quit Smoking _______ ( ) Years ( ) Months ago

Do you consume alcoholic beverages? ( ) Yes ( ) No
( ) light (<=1 drink/day) ( ) Moderate (2-3 drinks/day) ( ) Heavy (>3 drinks/day)

Age of Mattress: _____ Yrs, Is it ( ) Comfortable ( ) Uncomfortable
Do you wear ( ) Heel Lifts ( ) Sole Lifts ( ) Orthotics
Are you Pregnant? ( ) Yes ( ) No My most recent menstrual period began on ___________________________

Have you been in an automobile accident: ( ) Past Year ( ) Past 5 Yrs ( ) Over 4 Yrs
( ) Never. Please Describe: ____

____

____

List all operations\ surgery dates: ____

____

____

Please "X" below if you have suffered from any of the following conditions:

___ Cancer
___ Multiple Sclerosis
___ Nervousness
___ Heart Trouble
___ Dizziness
___ Backaches
___ Venereal Disease
___ Polio
___ Diabetes
___ Muscular Dystrophy
___ Scarlet Fever
___ High Blood Pressure
___ Concussion
___ Sinus Trouble
___ German Measles
___ Rheumatism
___ Convulsions
___ Arthritis
___ Rheumatic Fever
___ Epilepsy
___ Digestive Disorders
___ Hepatitis
___ Neuritis
___ Anemia
___ Grip Strength Loss
___Asthma
___Numbness

INSURANCE INFORMATION

Do you have health insurance: ( ) Yes ( ) No

Is your condition due to an automobile accident? ( ) Yes ( ) No

Is your condition due to and accident at work? ( ) Yes ( ) No

Insurance company name ______________________________Policy\ID number_____________________________

Group Number ________________________Policy Holders Name ____

SSN _______________ DOB ________________Policy Holders Employers Name ______________________________

Policy Holders home phone _____________________________ Work phone ________________________________

Secondary Insurance name ____________________________Policy\ID number_____________________________

Group Number ______________________Policy Holders Name ____

SSN _________________DOB_____________ Policy Holders Employers Name _______________________________

Policy Holders home phone _____________________________ Work phone ________________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Comfort Chiropractic will prepare any necessary reports and forms to assist me in making collection from my primary insurance company and that any amount authorized to be paid directly to Comfort Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that if I suspend or terminate my care and treatment in this office, any fees for professional services rendered me will be immediately due and payable. All overdue accounts will be assessed a service charge of 2% per month and will also be liable for all legal and collection fees.

I will be paying today by: ( ) Cash ( ) Check ( ) Visa ( ) Master Card ( ) Discover Card

Patients Signature ____Date ___________________________

Guardians or Spouse Signature ____Date ___________________________

FAMILY HEALTH INFORMATION

Many health problems are the result of hereditary spinal weakness: thus, information about your family will give us a better picture of your total health picture.

NAME	RELATION	HEALTH PROBLEM

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PATIENT PREGNANCY DISCLAIMER

My Signature below certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having x-rays taken at this time and grant permission for this procedure. In so doing, I release Dr. Orlasky from responsibility for potential damage arising from this procedure.

At the present time (please check one of the following),

________ I am sure that I am not pregnant.

________ It is possible that I may be pregnant.

________ I am pregnant.

____ ____________________
Signature of Patient and or Guardian Date

____ ____________________
Signature of Witness Date