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 ☐Declined to state

Your Employer:________________________ Address:______________________________ 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_____________

INSURANCE INFORMATION–*(You can skip Insurance information if you gave us your insurance card)*
Name of Insured:____ID #:______________________________

Relationship to Patient:______________________________ DOB:______________________________

Insurance Company:________________________________ Phone #_____________________ Group #:________________

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.

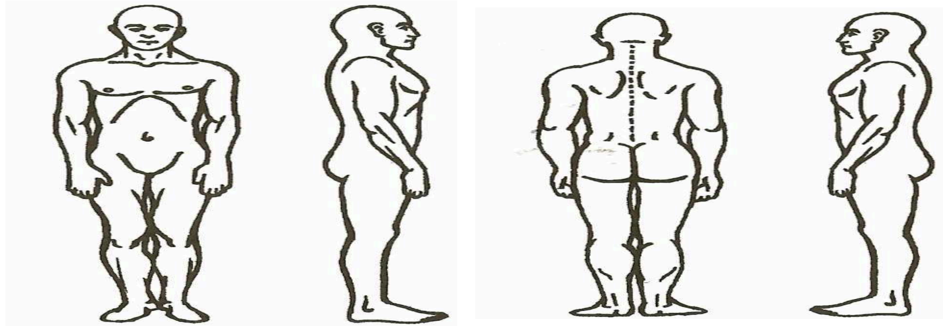
X____________________________________ _______________
Signature of Parent, Guardian or Personal Representative Date

Name:____ Date:______________________

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

PAIN = XXX

NUMBNESS or TINGLING =!!!



DATE PROBLEM BEGAN?____

WHAT CAUSED THE PROBLEM TO BEGIN?____

Have you had X-Rays / MRI / CT Scan of the problem area within the last 12 months? ☐ Yes ☐ No
Name of other doctors who have treated you for this condition:____
What treatment have you already received for this condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Care ☐Other_________________________________
Is this condition due to an accident? ☐ Yes ☐ No
If Yes, please provide: Date of accident:________________ Type of Accident: ☐ Auto ☐ Work ☐ Other

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

General:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Cancer
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Thyroid
- ☐ Gout
- ☐ Rheumatic fever
- ☐ Catch colds easily
- ☐ Hypoglycemia
- ☐ Rheumatoid arthritis
- ☐ Multiple sclerosis
- ☐ Depression
- ☐ Frequent influenza
- ☐ Osteoarthritis
- ☐ Tuberculosis
- ☐ HIV positive
- ☐ Parkinson’s disease
- ☐ Ulcers
- ☐ Hepatitis- type/s______
- ☐ Epilepsy/Seizures
- ☐ Pneumonia
- ☐ Venereal Disease
- ☐ Polio
- ☐ Skin Problems

Gastrointestinal:

- ☐ Gall bladder problem
- ☐ Heartburn
- ☐ Mucus in stool
- ☐ Liver trouble/Hepatitis
- ☐ Nausea
- ☐ Colitis
- ☐ Excessive thirst
- ☐ Diarrhea
- ☐ Hiatal hernia
- ☐ Distress from greasy food
- ☐ Blood in stool

Nervous System:

- ☐ Dizziness/Lightheaded
- ☐ Fainting
- ☐ Discoordination
- ☐ Memory loss

Eye, Ear, Nose and Throat:

- ☐ Vision problems
- ☐ Hearing loss
- ☐ Ear pain
- ☐ Ear noises
- ☐ Nose bleeds
- ☐ Frequent sinus trouble
- ☐ Difficulty breathing through nose
- ☐ Difficult speech
- ☐ Dental problems
- ☐ Hoarseness
- ☐ Sore throat

Urinary Tract:

- ☐ Blood in urine
- ☐ Inability to control urination
- ☐ Painful urination
- ☐ Bladder infection
- ☐ Kidney stones

Respiratory:

- ☐ Chest pain
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Spitting up phlegm
- ☐ Difficulty breathing
- ☐ Emphysema
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Allergies

Women Only:

- ☐ Irregular periods
- ☐ Headaches with period
- ☐ Premenstrual depression
- ☐ Hot flashes

Blood Sugar:

- ☐ Irritable before meals
- ☐ Heart palpitates w/skipped meals
- ☐ Get “shaky” if hungry
- ☐ “Lightheaded” if meals delayed
- ☐ Fatigue relieved by eating
- ☐ Abnormal craving for sweets/snacks

FAMILY HISTORY:

- ☐ Cancer
- ☐ Heart Problems
- ☐ Stroke
- ☐ Diabetes
- ☐ Rheumatoid Arthritis
- ☐ High Blood Pressure

Do you have a Pacemaker? ☐Yes ☐No
Do you have a Defibrillator? ☐Yes ☐No

List All Surgeries and Dates:_____________
____
____
____
____
____

List All Medications/Dosages:___________
____
____
____
____
____
____

List All Allergies:______________________
____
____

- ☐ Vomiting
- ☐ Metallic taste in mouth
- ☐ Constipation
- ☐ Burning in stomach relieved by eating
- ☐ Recent weight gain/ loss

Cardiovascular:

- ☐ Pain over heart
- ☐ Irregular heartbeat
- ☐ Low blood pressure
- ☐ Heart attack
- ☐ Stroke
- ☐ High blood pressure
- ☐ Swelling in ankles
- ☐ Shortness of breath on exertion
- ☐ Pressure over chest

- ☐ Menstrual cramps
- ☐ Painful breasts
- ☐ Vaginal discharge
- ☐ Excessive flow
- ☐ Lumps in breasts
- ☐ Menopausal symptoms
- ☐ Hysterectomy

Are you Pregnant? ☐Yes ☐No

Men Only:

- ☐ Burning on urination
- ☐ Need to get up at night to urinate
- ☐ Prostate trouble
- ☐ Difficulty starting urine
- ☐ Feeling of incomplete bowel evacuation
- ☐ Dripping after urination

Do you use tobacco products? ☐Yes ☐No
How long?___________________________
What type?___________________________

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
Have you considered hiring a person to do chores for you? 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 HAVE YOUR SYMPTOMS INTERFERED WITH YOUR USUAL DAILY ACTIVITIES?

☐**Not at all** ☐**A little bit** ☐**Moderately** ☐**Quite a bit** ☐**Extremely**

IN GENERAL, WOULD YOU SAY YOUR OVERALL HEALTH RIGHT NOW IS….

☐**Excellent** ☐**Very good** ☐**Good** ☐**Fair** ☐**Poor**