

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.

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 or Wk 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:

- | | | |
|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Concussion | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Neuritis |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> German Measles | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Grip Strength Loss |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> 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 1.5% 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