Apex Family Chiropractic and Wellness Center PC
1031 Pemberton Hill Road, Suite 201
Apex, NC 27502
p 919.363.2225
f 919.363.2280
apexfamilychiro.medicfusion.com

Patient Profile

Personal Information

Full Name: ______________________________ Jr / Sr
Last *First* *M.I.*

Address: ______________________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Primary Phone: ______________ H / M / B Alternate Phone: ______________ H / M / B

Birth Date: ____ / ____ / ____

Social Security Number #: ____ - ____ - ____

Gender: ☐ Male ☐ Female

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined ☐ Unknown/Unavailable
☐ Other ______________________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined ☐ Unknown/Unavailable

Prim. Language: ☐ Arabic ☐ Chinese ☐ English ☐ French ☐ German ☐ Greek ☐ Hebrew ☐ Italian
☐ Japanese ☐ Korean ☐ Spanish ☐ Vietnamese ☐ Declined ☐ Unknown/Unavailable
☐ Other ______________________________

Email Address: ______________________________

Emergency Contact: ______________ Emergency Contact Phone: ______________

Time Zone: ______________________________

Does your time zone participate in Daylight Savings Time? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Do you have any dependents? ☐ Yes ☐ No

Are you a full-time student? ☐ Yes ☐ No

Health Insurance? ☐ Yes ☐ No

Responsible Party: ☐ You ☐ Other (parent, spouse, etc.) ______________

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Control automated reminders

Patient Name: ____________________________

(Check each one to enable function)

	Confirmation	Reminders	Cancellations	No Shows
Email	☐	☐	☐	☐
Voice		☐		
Text		☐		

We are unable to send confirmation, cancellation, and no-show notifications via text and voice. However, with email, we will be able to send each one to your mailbox.

If you choose to enable any of the above functions, please provide to us the following information:

Current email address you wish to use for notifications: ________________________________

Current mobile device to receive voice and text reminders: ________________________________

The number of hours in advance you wish to be notified:

- o 24
- o 48
- o 72

Allow emails that do not pertain to PHI?

- o Yes
- o No

Personal Health Information (PHI) may be communicated in the following way:

- ☐ **Patient has no preference- any generally acceptable means.**
- ☐ **In person only**
- ☐ **Patient will call to discuss**
- ☐ **Patient preferences specified: (You may check more than one option below)**
  - ☐ **Mailing address may be used for written communication.**
  - ☐ **Email may be used for written communication. (Patient understands the risks)**
  - ☐ **Phone number:** __________________ **(check each one you wish to enable)**

o Answer	o Voice	o Text

- ☐ **Patient declined to specify.**
- ☐ **Other means:**

CHIEF COMPLAINT FORM

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Patient:______________________________________

Vitals (office use only): H: _____ W: _____ BP: ____/____ L R

Pulse: _____ Temp: _____ Pulse Ox:_____ Respirations: ______

Describe the reason for your visit:

When did your symptoms begin? (if unknown, please estimate) ____/____/___

For Women Only: Most recent menstrual cycle: ____/____/____ Are you pregnant? Yes (Approx. Due Date)___/___/___ No

Which word describes the frequency of your discomfort? (Please Circle One)

Constant (75-100%) Frequent (51-75%) Intermittent (26-50%) Occasional (0-25%)

Which phrases best describe *changes* in your discomfort during the day? (Please circle one or more)

Worse in the morning Worse in the afternoon Worse at night Changes with the weather Does not Change

What helps *relieve* your discomfort? (Circle one or more)

Ice Heat Medication Physical Therapy Acupuncture Massage Nothing

Other: ____

What activities are limited by your discomfort? (Circle all that apply)

Bending Bowel Movement Coughing Daily Routine Driving Getting Up Lifting Lying Down Pulling

Pushing Reading Sitting Sleeping Sneezing Standing Turning Head Urination Walking Working

Other:____

Where applicable, specify the approximate date of your most recent: (month / year)

Physical Exam:____/____ Dental Xray:____/____ Spinal Xray:____/____

MRI:____ /____ Location:____________ CT Scan:____/____ Location:_________ Other Scans:____/___Location:___________

Have you tried other medical treatments (physical therapy, chiropractic, etc...) NO YES

Specify Treatment Provider: Hospital or Urgent Care Medical Physician Chiropractor Massage Therapist

Physical Therapist Acupuncturist Other:___________________________________

Approx Start Date of Prior Treatment: ____/____/____ **Approx. End Date of Prior Treatment:** ___/____/____

This office may require a copy of the medical report detailing your treatment. If needed... (Circle One)

I will provide a copy I will fax it I will email it I authorize my former facility to release my records.

Is the injury resulted from an Auto accident? NO YES If yes date of accident_____/_____/____

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Patient Medical History

Prescription Medications, OTC Medications, and Dietary Supplements

Prescription medications taken on a regular or ongoing basis: (If you have more than 5 medications, please bring list to next appointment)

Medication/Supplement:	Dosage:	Frequency: Day Week Month Other_______
Medication/Supplement:	**Dosage:**	**Frequency: Day Week Month Other_______**
Medication/Supplement:	Dosage:	Frequency: Day Week Month Other_______
Medication/Supplement:	Dosage:	Frequency: Day Week Month Other_______
Medication/Supplement:	Dosage:	Frequency: Day Week Month Other_______

*Diet and Exercise

Check if you have ever smoked cigars or cigarettes. o Yes Start Date:_____________

Stop Date:______________

Check if you still smoke.	o	Yes How much?_______________
Check if you drink alcoholic beverages.	o	Yes How much per week?
Have you been diagnosed as an alcoholic?	o	Yes
Has a physician diagnosed you with any liver-related problems?	o	Yes
Check if you exercise regularly.	o	Yes How much per week?____________

*Allergies (Please List any Allergies):

*Surgical History

Please list any foreign objects in your body.				
Please list any surgeries w/ year.		Year:		Year:
		Year:		Year:

*Cancer History: Have you been diagnosed with cancer? If so, please list.

Has anyone in your family been diagnosed with cancer? If so, please list and specify family members.

Past Medical History (Please check if you have been diagnosed with any of the following):

Asthma	Hypertension	Hypotension	Anemia
Emphysema	Hemorrhoids	COPD	Hepatitis
Chronic Bronchitis	Tuberculosis	Sickle Cell	Pneumonia
Chicken Pox	Diabetes	Measles	Mumps
Seizures	Crohn's Disease	Kidney Disease	Liver Disease
Headaches: Tension Stress Induced Cluster Migraine Sinus			
Stomach Ulcers	UTI	Shingles	Thyroid Dysfunction
Anxiety Disorders	ADHD	Depression	Eating Disorders
Phobic Disorders	PTSD	Sleep Disorders	Suicidal Disorders
OCD	Substance Abuse	Seasonal Affective Disorder	Autism
Blindness	Deafness	Glaucoma	Sinusitis
Vertigo	Cataract	Tinnitus	Eczema
Carpal Tunnel	Osteoarthritis	Fibromyalgia	Osteoporosis
Lyme Disease	Gout	Herniated Disk	Multiple Sclerosis
Numbness in the feet		Numbness in the hands	
Polio	Pinched Nerve	Sciatica	Parkinson's Disease
Rheumatoid Arthritis	TMJ	Ankylosing Spondylitis	Schleroderma
ED	HPV	Menopause	Yeast Infections
Infertility	Fibroids	Infertility	Dysplasia
Other:			
Other:			

Family History (Has a family member been diagnosed with the following? Please circle family member)

F-Father M-Mother S-Sibling MG-Maternal Grandparent PG-Paternal Grandparent

Asthma	F M S MG PG	COPD	F M S MG PG
Hypertension	F M S MG PG	Hepatitis	F M S MG PG
Hypotension	F M S MG PG	Chronic Bronchitis	F M S MG PG
Anemia	F M S MG PG	Tuberculosis	F M S MG PG
Emphysema	F M S MG PG	Sickle Cell	F M S MG PG
Hemorrhoids	F M S MG PG	Pneumonia	F M S MG PG
Other:	F M S MG PG	Other:	F M S MG PG
Other:	F M S MG PG	Other:	F M S MG PG

Women Only:

Check if you have ever given birth o Yes

How many births vaginally? _____

How many births by C-section? _____