

RAYA CLINIC

200 Queen Street ♦ Southington, CT 06489 ♦ 860-621-2225

CONFIDENTIAL PATIENT INFORMATION

Full Name _____ Date _____

Mailing Address _____
Street City State Zip

Home Phone () _____ Work Phone () _____

Mobile Phone () _____ E-Mail address _____

Social Security # _____ Spouse/Guardian Name _____

Marital Status: M S W D Age _____ Birth Date _____ No. of children _____

Spouse/Emergency Contact Phone _____

Occupation _____ Employer's Name and Address _____

Name of person responsible for account _____ Whom may we thank for referring you? _____

Assignment (if applicable) and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Advanced Back Center 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am responsible for obtaining a referral if necessary. I authorize the release of my X-rays and medical records from any provider, hospital, attorney or insurance company.

Reponsible Party Signature _____

Relationship (Self/parent/spouse) _____

Date _____

I. Primary Complaint: _____

Location of primary complaint: _____

Pain Scale: 0 (No Pain) 10 (Worst Pain)

Current Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At its Worst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At its Best	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How did it start? _____ How long ago? _____

What makes it feel better? _____

What makes it feel worse? _____

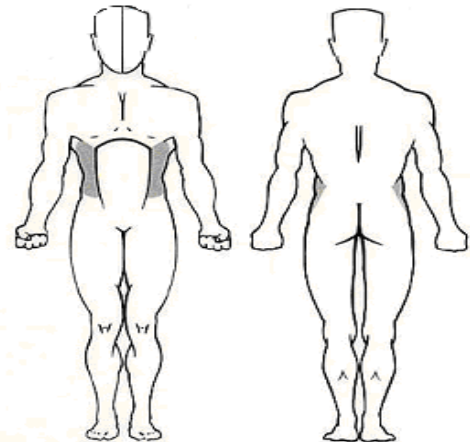
Does the pain radiate anywhere? _____

Have you had a MRI, X-ray, CTscan on this area? Yes/No Where? _____

Does it hurt more in Morning /Afternoon/ Night/All Day (please circle)

Have you seen anyone for this condition? Yes/No

If yes who? Name: _____ Phone: () _____



Please Mark the areas on your body where you feel the following sensations:

Pain ^^^ Numbness ooo Pins and Needles

... Burning xxx Stabbing /// Other +++

Secondary Complaint: _____

Location of primary complaint: _____

Pain Scale: 0 (No Pain) 10 (Worst Pain)

Current Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At its Worst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At its Best	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How did it start? _____ How long ago? _____

What makes it feel better? _____

What makes it feel worse? _____

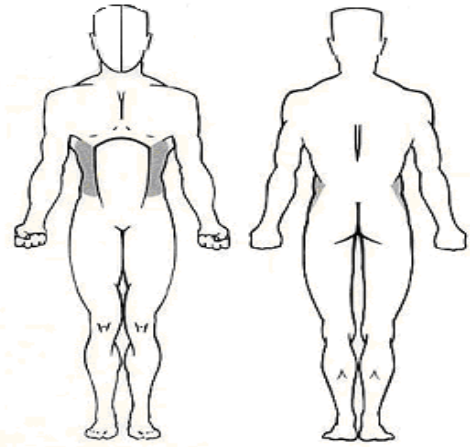
Does the pain radiate anywhere? _____

Have you had a MRI, X-ray, CTscan on this area? Yes/No Where? _____

Does it hurt more in Morning/ Afternoon/ Night/ All Day (please circle)

Have you seen anyone for this condition? Yes/No

If yes who? Name: _____ Phone: (____) _____



Please Mark the areas on your body where you feel the following sensations:

Pain ^^^ Numbness ooo Pins and Needles
... Burning xxx Stabbing /// Other +++

Third Complaint: _____

Location of primary complaint: _____

Pain Scale: 0 (No Pain) 10 (Worst Pain)

Current Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At its Worst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At its Best	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How did it start? _____ How long ago? _____

What makes it feel better? _____

What makes it feel worse? _____

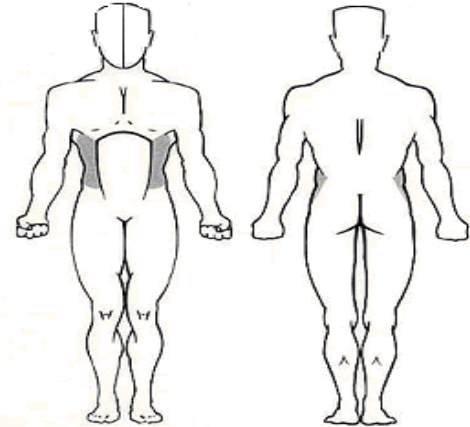
Does the pain radiate anywhere? _____

Have you had a MRI, X-ray, CTscan on this area? Yes/No Where? _____

Does it hurt more in Morning/ Afternoon/ Night/ All Day (please circle)

Have you seen anyone for this condition? Yes/No

If yes who? Name: _____ Phone: (____) _____



Please Mark the areas on your body where you feel the following sensations:

Pain ^^^ Numbness ooo Pins and Needles
... Burning xxx Stabbing /// Other +++

II. Past Medical History

Please list any surgeries you have had and the date: _____

List of Medications you are currently on: _____

Any additional concerns please note

III. HEALTH HISTORY:

Mark the following conditions you may have had or have now (“-“ have had, “+” have now)

- | | | | | | |
|--------------------------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------------|-------------------------------------|------------------------------------------|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> HIV (AIDS) | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Neuritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Malaria | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Polio | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Migraines | <input type="checkbox"/> Headaches | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Other: (Please Explain) _____ | | | | | |

IV. Social History – Example: Smoking, Drinking, Exercising How Long or how much?

Have you been in an auto accident? Yes/No Past year Past 5 years Over 5 years Never

Describe _____

Have you had any other personal injury or accident? Past year Past 5 years Over 5 years

Do you currently have an open workman’s compensation or personal injury case? Yes / No

If you have an open case, please tell us your attorney’s name : _____

V. SERVICES

Please check all the services you wish to receive or may be interested in:

- Chiropractic:**
- Adjustments
 - Physical Therapy
 - Exercises

- Turbosonic:**
- Weight Loss
 - Osteoporosis
 - Strength Training
 - Increased Energy

- Acupuncture:**
- Emotional Issues
 - Addictions
 - Fatigue
 - Chronic Pain
 - Insomnia/Sleeping Disorders
 - Stop Smoking
 - Appetite Control

- Nutrition:**
- Saliva Test (Hormone Levels)
 - Contact Reflex Analysis (Nutritional Analysis)
 - Vitamins/Supplements
 - Allergy Food Testing
 - Hair Test (Screen for toxic metals and minerals)
 - Detoxification of Liver and Intestines

- Orthotics:**
- Foot Scans/Analysis

- Postural:**
- Pillow Test
 - Sleep Position Instruction

- SpineMED Decompression Therapy:**
- Herniated Discs
 - Stenosis

VI. STRESSES

The following tree areas of stress can cause a misaligned vertebra and nerve system interference. Please circle when you experienced these stresses: C (Child), T (Teenager), A (Adult), or N (Not at all).

PHYSICAL STRESS:

	C	T	A	N	<u>Explain</u>
Birth Traumas (as a mother or child)					_____
Slips/Falls					_____
Car Accidents					_____
Sports Injuries					_____
Physical abuse					_____
Work Injuries					_____
Poor Posture					_____
Sitting on your wallet for years					_____
Sleeping Position – Stomach					_____
Extensive Computer Work					_____
Carrying Heavy Purse/Bookbag/Child					_____
Repetitive Lifting/Bending					_____
Driving for Many Hours					_____
Continuous Hour Sitting/Standing					_____
Bone Fracture/Surgery					_____

EMOTIONAL/MENTAL:

	C	T	A	N	<u>Explain</u>
Relationships					_____
Career					_____
Children					_____
Money					_____
Fast-Paced Life					_____
Hold in Feelings					_____
Quick Tempered					_____
Verbal Abuse					_____
Perfectionist					_____
Procrastinator					_____
Sickness or Loss of Loved One					_____

CHEMICAL:

	C	T	A	N	<u>Explain</u>
Environment (i.e. pollution)					_____
Smoker-Amount?					_____
Second-hand smoke					_____
Poor diet					_____
Caffeine – Amount?					_____
Excessive Sugar					_____
Artificial Sweeteners					_____
Prescription Drugs					_____
Over-the-counter Drugs					_____

VII. Family History: Some health conditions are the result of hereditary weakness. Information about immediate family members, brothers, sisters, parents, grandparents will give us a better understanding of your total health picture.

Relationship

Present and Past Health Problems
