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 (**)___________________________________ Mobile Carrier: AT&T Sprint Verizon T-Mobile Other

***Email Address** :____ Preferred Method Of Contact: __________________________

Is it okay to leave detailed messages on the phone numbers provided? Yes or No

Social Security #_____________________________________ Spouse/Guardian Name_______________________________

Marital Status: M S W D Age_________ Sex: M F T Birth Date____________________No. of children__________

Spouse/Emergency Contact Phone____

Primary Care Physician____ Phone: _____________________________________

Is it okay to leave detailed messages for your Emergency Contact? Yes or No

Occupation_______________________ Employer's Name and Address ____

Name of person responsible for account_________________________How did you hear about us?__________________

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:____
____

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

Current Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At its Worst	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At its Best	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

How did it start? ______________________ How long ago? _____________

What makes it feel better? _______________________________________

What makes it feel worse? ____

Does the pain radiate anywhere? ___________________________________

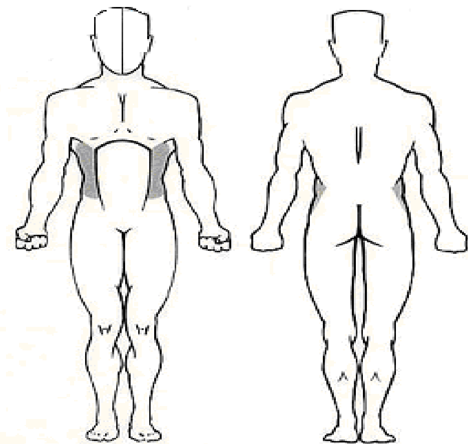
Have you had a MRI, X-ray, CTscan on this area? Yes/No Where?________

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: (___) ___________

Location of primary complaint:



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

Current Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At its Worst	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At its Best	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

How did it start? ______________________ How long ago? _____________

What makes it feel better? ____

What makes it feel worse? ____

Does the pain radiate anywhere? ____________________________________

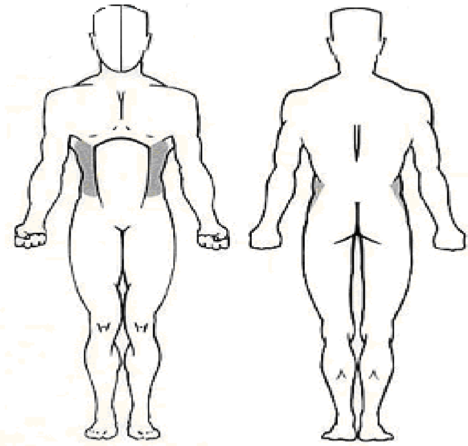
Have you had a MRI, X-ray, CTscan on this area? Yes/No Where?________

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: (___) ___________

Location of primary complaint:



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

Current Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At its Worst	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At its Best	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

How did it start? ______________________ How long ago? _____________

What makes it feel better? ____

What makes it feel worse? ____

Does the pain radiate anywhere? ____________________________________

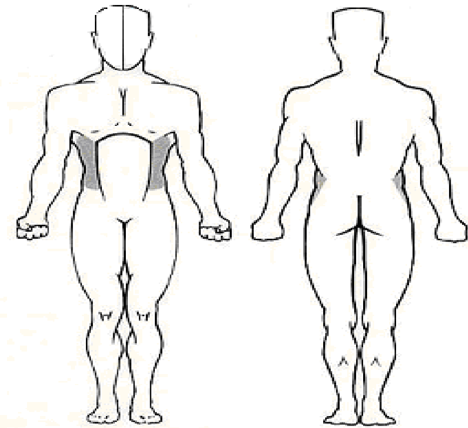
Have you had a MRI, X-ray, CTscan on this area? Yes/No Where?________

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: (___) ___________

Location of primary complaint:



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)

___Allergy	___Diarrhea	___Measles	___Rheumatic Fever	___Alcoholism	___Eczema
___Miscarriage	___Stroke	___Anemia	___Multiple Sclerosis	___HIV (AIDS)	___Gout
___Arteriosclerosis	___Emphysema	___Mumps	___Sinus Problems	___Arthritis	___Neuritis
___High Blood Pressure	___Asthma	___Nervousness	___Thryroid Problems	___Ulcers	___Cancer
___Heart Disease	___Depression	___Convulsions	___Venereal Disease	___Malaria	___Pleurisy
___Constipation	___Pneumonia	___Cold Sores	___Whooping Cough	___Polio	___Neck Pain
___Gall Bladder Problems	___Migraines	___Headaches	___Menstrual Cramps	___Back Pain	___Epilepsy
___Irregular Periods	___ Heart Attack	___Tuberculosis	___Low Blood Sugar	___ Diabetes	___Ringing in Ears

___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

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

Orthotics:
- ☐ Foot Scans/Analysis

SpineMED Decompression Therapy:
- ☐ Herniated Discs
- ☐ Stenosis

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

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

Postural:
- ☐ Pillow Test
- ☐ Sleep Position Instruction

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

EMOTIONAL/MENTAL:					Explain
Relationships	C	T	A	N	___
Career	C	T	A	N	___
Children	C	T	A	N	___
Money	C	T	A	N	___
Fast-Paced Life	C	T	A	N	___
Hold in Feelings	C	T	A	N	___
Quick Tempered	C	T	A	N	___
Verbal Abuse	C	T	A	N	___
Perfectionist	C	T	A	N	___
Procrastinator	C	T	A	N	___
Sickness or Loss of Loved One	C	T	A	N	___

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

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
___	___
___	___
___	___
___	___