Dr. Robert A. Schroter
108 Blue Ridge Hwy, Suite 12
Blairsville, GA 30512

HIPPA
Protected Health Information
Authorized Access Only

CONFIDENTIAL PATIENT INFORMATION

The following information is needed in order to better serve you. Please complete ALL questions. If you need help, please ask the receptionist. PLEASE PRINT

Today's Date _____________________ Referred By ______________________________

Name ______________________________ Age _____ Date of Birth ____________ # of Children ________
Address______________________________ City___________________ State______ Zip Code___________
Phone (home): ____________________ (cell): _________________ Social Security # __________________
Emergency Contact _________________ Phone #___________________ E-mail: _____________________
Marital Status S M D W Spouse (or Parent) _______________________ Date of Birth: _____________
Occupation ________________ Employer_________________ City ___________State _______ Zip________
Primary Insurance Company____________________________ Plan/Group# __________________________
Secondary Insurance Company__________________________ Plan/Group# __________________________
Is your condition due to an accident? Yes___ No___ If yes, date of accident __________________________
Type of accident: Auto___ Work___ At home___ Other/explain ___________________________________
Have you ever been in an auto accident? Yes___ No___ When ______________________________________
Have you ever been in an industrial accident? Yes___ No___ When/explain ___________________________
Please describe the major complaints that brought you to our office: ________________________________
____
____

Mark the area on the figures where you a experiencing pain, include a number from 1-10 (1 being mild, 10 being severe)

Check the activities below during which you experience difficulty or pain:

___Lying on back
___Lying on side knees bent
___Turning over in bed
___Lying flat on stomach
___Standing for over one hour
___Reaching
___Stooping
___Bending forward
___Bending backward
___Gripping
___Dressing self
___Getting in/out
___ Sneezing
___ Coughing
___ Kneeling
___ Sitting
___ Walking
___ Pushing
___ Climbing
___ Sleeping
___ Pushing
___ Pulling
___ Other

Additional comments: ______________________________
____

List all current health problems: ____
____
____
____Initial _________

List all surgeries/hospitalizations and dates: ____
____
____
____

List current doctors seen and reason: ____
____
____
____

Please check any conditions you have or have had:

___ AIDS or HIV+	___ Epilepsy	___Polio
___Anemia	___Hypoglycemia	___Rheumatic Fever
___Arthritis	___Autoimunity	___Tuberculosis
___Cancer	___Parkinson's Disease	___Venereal Disease

Any health issues that run in either your family of your spouse's family: ______________________________
____

Do you have a family physician? Yes___ No___ Name ____________________ Phone ___________________
Address __________________________________ City________________ State_____________ Zip________
Date of last physical_________________________________ Date of last blood workup__________________
Have you ever seen a chiropractor before? Yes___ No___ If yes, please list:
Doctor__________________ Dates_________________ Doctor___________________ Dates_____________
Was your experience with your chiropractor favorable? Yes___ No___ Explain __________________________
____
List any allergies you have ____
Any additional information you would like the doctor to know before beginning treatment at Schroter Chiropractic Center ____
____
____

Social History

Smoking Yes___ No___ Amount_____________
Other tobacco use________________________
Alcohol use Yes___ No___ Amount_________
Coffee Yes___ No___ Amount_______________
Tea Yes___ No___ Amount _______________

Diet is balanced___ unbalanced___
Rest is sufficient___ insufficient___
Recreation is sufficient___ insufficient___

Family stress is: Severe ___ Moderate___ Minimal___ None___

Job stress is: Severe___ Moderate___ Minimal___ None___

I like my job: Very much____ It's OK ___ I hate it ___

Nervousness___ Irritability___ Fatigue___ Depression___ Anxiety___
Feel unhealthy___ Desperate for change___ Feel trapped___ Uncertain of future___

The following two pages should be answered as honestly and accurately as possible. Please take your time and be thorough because the information obtained is extremely important to Dr. Schroter and his ability to make a differential diagnosis and come to the most accurate conclusions about your health.

Initial _______