PLYMOUTH GROVE CHIROPRACTIC, P.A.

Dr. Vivi-Ann R. Fischer

Date__________________ Email ____________________

Cell Phone ________________

Name________________________________ (First MI Last) Name you preferto be called in this office ____________________ Home Phone _____/_______________ (Area Code)

Address ____ City __________________Zip _________________

Date of Birth ___________ Age __________ Marital Status M S D Spouse __________________# of Children __________

Your Occupation __________________________ Employer _______________________ Your SS#___________________

Employer Address ____ Work Phone _____/_____________________ (Area Code)

Insured's Name ___________________________ Insured's Address ____

Insured's Date of Birth ______________________ Insurance Company ____________________________________

Employer_________________________________ SS# ___________________________Policy ID# _________________

Employer address_____________________________How did you hear about us? _________________________________

In case of emergency contact: (Name, Address, Phone #) ____

____Are you a student ___No ___Yes ☐ Part-Time ☐ Full-Time

Present	Past	
		Muscle/Skeletal System
☐	☐	Joint Pain
☐	☐	Muscle Pain
☐	☐	Headache
☐	☐	Migraine
☐	☐	Neck Pain/Stiffness
☐	☐	Shoulder
☐	☐	Wrist/Hand
☐	☐	Elbow
☐	☐	Middle Back Pain
☐	☐	Low Back Pain
☐	☐	Pain Radiating Below Waist
☐	☐	Hip
☐	☐	Knees
☐	☐	Ankle/Feet
☐	☐	Scoliosis
☐	☐	Arthritis
☐	☐	Tendonitis
☐	☐	Bursitis
		Digestive System
☐	☐	Indigestion/Gas
☐	☐	HeartBurn
☐	☐	Diarrhea/Constipation
☐	☐	Hiatal Hernia
☐	☐	Food Intolerance/Allergy
☐	☐	Abdominal Pain
☐	☐	Ulcers

Present	Past	
☐	☐	Infant Colic
☐	☐	Appendicitis
☐	☐	Gall Bladder Trouble
☐	☐	liver Problems
☐	☐	Nausea or Vomiting
☐	☐	Poor or excessive appetite
		Nervous System
☐	☐	Nervousness
☐	☐	Depression
☐	☐	Insomnia/Sleeping Difficulty
☐	☐	Epilepsy/Seizures
☐	☐	Fainting Spells/Dizziness
		Urinary System
☐	☐	Frequent Urination
☐	☐	Painful Urination
☐	☐	Kidney Stone or Infection
☐	☐	Prostate Trouble
☐	☐	Difficulty Controlling Urine
☐	☐	Frequent Bladder or Vaginal Infections
		Respiratory System
☐	☐	Congestion of Head
☐	☐	Sinus
☐	☐	Congestion of Lungs
☐	☐	Allergies
☐	☐	Asthma
☐	☐	Emphysema

Present	Past	
☐	☐	Pleurisy
☐	☐	Pneumonia
☐	☐	Chest Pain
☐	☐	Pain With Taking a Deep Breath
		Endocrine System
☐	☐	lack of Drive/Energy
☐	☐	Acne
☐	☐	Bedwetting
☐	☐	Diabetes
		Women
☐	☐	Irregular Menstruation
☐	☐	PMS
☐	☐	Endometriosis
☐	☐	Hot Rashes/Menopause
☐	☐	Difficult labor
☐	☐	Back Pain with Pregnancy
		Immune System
☐	☐	Frequent Colds and Flu
☐	☐	Ear Infections
☐	☐	Tumors/Cancer
☐	☐	Shingles
☐	☐	Psoriasis
☐	☐	Hemorrhoids
☐	☐	Gout
☐	☐	Herpes
☐	☐	AIDS
☐	☐	Venereal Disease

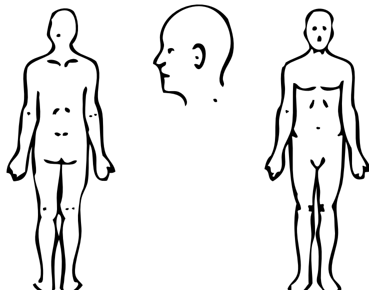
Present	Past	
☐	☐	Hepatitis
☐	☐	Tuberculosis
		Circulatory System
☐	☐	High Blood Pressure
☐	☐	Varicose Veins
☐	☐	High Cholesterol
☐	☐	Heart Disease
☐	☐	Pacemaker
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Anemia
☐	☐	Stroke
☐	☐	Rapid Heart Beat
		General Health History
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Anorexia/Bulemia
☐	☐	Fatigue
☐	☐	Mumps
☐	☐	Multiple Sclerosis
☐	☐	Polio
☐	☐	Chicken Pox
☐	☐	Alcoholism
☐	☐	Fever, Chills or Sweats
☐	☐	Thyroid

Check the type of care desired so we may be guided by your wishes whenever possible.

_______Temporary Relief _______ Control of immediate problem _______The care the doctor feels is the best care for me.

Mark area of pain or injury on the illustration below with a brief description of the symptoms.

Date symptom(s) first noticed _________________ Problem(s) was caused by ______________________________



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OUR PERSONAL CONCERN: Our professional and personal concern is with just two things: Your Health and Our Reputation. Therefore, we accept only those patients whom we Sincerely believe we can help.

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Dr. Vivi-Ann R. Fischer

Have you had similar problem(s) ☐ Yes ☐ No
Have you had previous trauma(s)/accidents such as car accidents or falls
☐ Yes ☐ No
Symptoms hurt most when you ☐ Sit ☐ Cough/Sneeze
☐ Get up from chair ☐ Walk up/down stairs ☐ Bend ☐ Turn head
☐ Morning ☐ Afternoon ☐ Night ☐ Other
Have you consulted another Health Professional for this problem?
☐ Yes ☐ No
Were X-rays taken ☐ Yes ☐ No CAT SCANs/MRI taken ☐ Yes ☐ No
Name of your Family Physician ______________________
Date of last ________Physical ________Blood test ________Urine test
Date of last Chiropractic adjustment ______________________
Have you gained or lost 10 pounds in the last year ☐ Yes ☐ No
What is your height? ____________ Present weight? ____________
Are you pregnant ☐ Yes ☐ No Expected delivery date ______________
List all surgeries and dates ______________________

____

List all medications taken in past few years ______________________

____

List family history health problems, i.e. Cancer, Diabetes, Heart Disease

____

Lifestyle Considerations

How many cups of coffee per day ______________________
Cigarettes per day ______________________
Cans of pop per day ______________________
Glasses of alcohol/beer per day ______________________
Glasses of water per day ______________________
Type of pillow: Foam Feather Cervical Orthopedic ______________
Type of mattress you use: ☐ Conventional ☐ Waterbed
How old is mattress ______________________
How many hours of sleep per night ______________________
During your day you primarily: ☐ Sit ☐ Stand ☐ Drive
Do you take vitamins: ☐ Yes ☐ No
Do you exercise/stretch ☐ Yes ☐ No

____

SIGNATURE ON FILE

THE UNDERSIGNED HEREBY AUTHORIZES THE RELEASE OF ANY INFORMATION RELATING TO ALL CLAIMS FOR BENEFITS SUBMITTED ON BEHALF OF MYSELF AND/OR DEPENDENTS. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE ON THIS DOCUMENT AUTHORIZES MY CHIROPRACTOR TO SUBMIT CLAIMS FOR BENEFITS, FOR SERVICES RENDERED OR FOR SERVICES TO BE RENDERED, WITHOUT OBTAINING MY SIGNATURE ON EACH AND EVERY CLAIM TO BE SUBMITTED FOR MYSELF AND/OR DEPENDENTS, AND THAT I WILL BE BOUND BY THIS SIGNATURE AS THOUGH THE UNDERSIGNED HAD PERSONALLY SIGNED THE PARTICULAR CLAIM.

I, ______________________________________ HEREBY AUTHORIZE
(Name of Patient)

______________________________________ TO PAY AND HEREBY ASSIGN
(Name of Insurance Company)

DIRECTLY TO DR. VIVI-ANN FISCHER, ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES AS DESCRIBED ON THE ATTACHED FORMS. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED LESS ANY INSURANCE BENEFITS WHEN RECEIVED BY AND PAID TO DR. VIVI-ANN FISCHER. AUTHORIZATION IS HEREBY GIVEN TO RELEASE ALL INFORMATION NECESSARY TO THE PAYMENT OF SAID BENEFITS.

____
(sign here) (Authorized signature of Covered Person/Employee)

____
(Date)

MINOR CHILD RELEASE

I GIVE MY PERMISSION TO DR. VIVI-ANN FISCHER AND/OR HER DESIGNATED ASSISTANT(S) TO PERFORM ANY AND ALL CHIROPRACTIC TECHNIQUES AND PROCEDURES, INCLUDING BUT NOT LIMITED TO THE EXAMINATION, X-RAY AND TREATMENT ON , ______________________ A MINOR, WHETHER OR NOT I AM PRESENT AT THE ACTUAL APPOINTMENT WHEN THE TREATMENT IS RENDERED. I FURTHER EXPRESSLY AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL TREATMENT RENDERED TO THE ABOVE-NAMED CHILD(REN).

SIGNED ______________________________________ DATE ______________________