WELCOME

Faulkner Sports Medicine & Chiropractic, LLC DBA: Apex Sports Medicine

PERSONAL INFORMATION

First Name:_____ **M.I.**_____ **Last Name**:_____ **Preferred Name**: _____

Address:_____ **City**:_____ **State**:_____ **Zip**:_____

Birthdate:_____ **Age**____ **Gender**: _____ **Height:** _____ **Weight:** _____lbs. **SSN**:_____

Primary Phone: _____ **Cell Phone**: _____ **Work Phone**: _____

Email:_____ By providing my email address, I authorize my doctor to contact me via the email address provided.

Contact Method: (check one) ☐ Primary Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Status: (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated **Spouse's Name**: _____

Occupation:_____ **Employer**: _____

Emergency Contact: (Name, Relationship, Phone #) _____

PCP Name:_____ **Can we follow up with your PCP about your care in our office?** □ Yes □ No

Coach/Trainer Name:_____ **Can we follow up with your coach or trainer about your care in our office?** □ Yes □ No

How were you referred to Apex Sport Medicine? _____

INSURANCE OR PRIVATE PAY INFORMATION

Please provide insurance card(s) to receptionist. (Insurance information does NOT APPLY to acupuncture, cupping therapy, or massage)

Type of Insurance: ☐ Private Ins. ☐Medicare ☐ Other ☐ Private Pay-By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Apex Sports Medicine chiropractors are NOT Medicare or Medicaid providers.

Name of person responsible for this account:_____ **Primary Insurance Carrier**: _____

Phone:_____ **Policy #**:_____ **Group #**:_____ **Claim #**: _____

Name of Policy Holder:_____ **Relationship to Patient**: _____

Policy Holder's Birthdate:_____ **Policy Holder's SSN**: _____ **Employer**: _____

REASON FOR VISIT

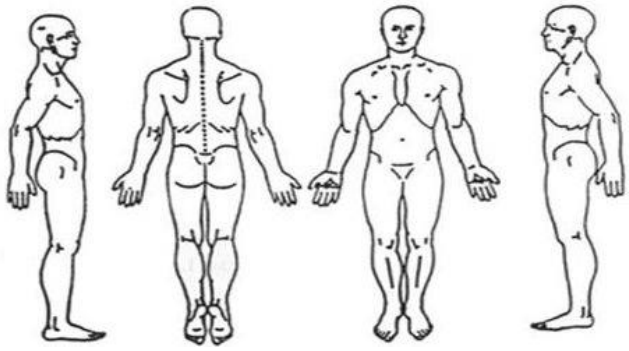
1) What is the reason for your visit today?_____

2) What caused this complaint(s)?_____

3) When did this complaint begin? _____

4) Is it getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes ☐ Improving

5) Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.



6) On a scale of 1 to 10, how would you rate the severity of your main complaint right now?

No pain Moderate pain Worst possible pain

0	1	2	3	4	5	6	7	8	9	10

7) What area(s) does the pain radiate, shoot, or travel to? (if applicable)?

_____

Apex Sports Medicine, 2303 S. Bagdad Rd. #200 Leander, Tx. 78641 Phone: 512-528-6009 Fax:512-528-3690

8) What does your complaint (s) feel like? Check all that apply:

☐ Sharp	☐ Tight	☐ Stabbing	☐ Nagging
☐ Dull	☐ Aching	☐ Shooting	☐ Tingling
☐ Sore	☐ Spasms	☐ Burning	☐ Numbness
☐ Stiff	☐ Throbbing	☐ Cramping	☐ Other _____

9) Timing of complaint: Check appropriate box**:**

☐ Morning	☐ Evening	☐ After activities	☐ Other:
☐ As day progresses	☐ While sleeping	☐ Symptoms are constant	_____
☐ Afternoon	☐ During activities		

10) How often do you experience your symptoms? Check all that apply:

☐ 25% of the day	☐ 50% of the day	☐ 75% of the day	☐ 100% of the day

11) What aggravates this complaint? Check all that apply:

☐ Sitting	☐ Sleeping	☐ Twisting	☐ Everything
☐ Standing	☐ Physical Activity	☐ Reaching	☐ Unknown
☐ Walking	☐ Exercise	☐ Lifting	☐ Other _____
☐ Getting up from seat	☐ Movement	☐ Desk work	
☐ Walking stairs	☐ Bending forward	☐ Sneezing	
☐ Inactivity	☐ Bending backward	☐ Coughing	

12) What relieves this complaint? Check all that apply:

☐ Sitting	☐ Exercise	☐ Chiropractic	☐ Medication
☐ Standing	☐ Movement	☐ Heat	☐ Nothing
☐ Walking	☐ Stretching	☐ Ice	☐ Unknown
☐ Resting	☐ Massage	☐ Laying down	☐ Other _____

13) Is your complaint interfering with your daily activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

14) Is this condition interfering with your: Check all that apply:

☐ Sleep	☐ Work	☐ Getting in or out of bed or chair	☐ Exercise
☐ Social Activities	☐ Recreation	☐ Standing	☐ Other: _____
☐ Personal care	☐ Lifting	☐ Daily Routine	
☐ Travel	☐ Walking		

15) Have you had this or similar complaint in the past? ☐ Yes ☐ No If "Yes", when? _____

16) Have you seen other doctors for this complaint? ☐ Yes ☐ No If "Yes", please provide the following information:

Doctor's name:_____ Date consulted:_____ Diagnosis _____

17) Have you had an X-ray or CT scan or MRI in the past 28 days? ☐ Yes ☐ No **Explain**: _____

18) What are your treatment goals? _____

Apex Sports Medicine, 2303 S. Bagdad Rd. #200 Leander, Tx. 78641 Phone: 512-528-6009 Fax:512-528-3690

HEALTH HISTORY

1) Check all that apply

Musculoskeletal

Past	Current	
□	□	Fracture
□	□	Scoliosis
□	□	Osteoporosis
□	□	Implants or plates
□	□	Pins or screws
□	□	Gout
□	□	Arthritis
□	□	Swelling, redness of joints
□	□	TMJ issues

Neurological

Past	Current	
□	□	Anxiety
□	□	Depression
□	□	Difficulty concentrating
□	□	Dizziness
□	□	Epilepsy or seizures
□	□	Headache
□	□	Loss of smell or taste
□	□	Memory issues
□	□	Numbness
□	□	Pins and needles
□	□	Sleeping issues
□	□	Stroke
□	□	Weak muscles

Endocrine

Past	Current	
□	□	Cushing's syndrome
□	□	Diabetes
□	□	Excessive thirst
□	□	Feeling hot or cold
□	□	Heat or cold intolerance
□	□	Hyperparathyroidism
□	□	Increase size of hands or feet
□	□	Increase urination
□	□	Pancreatic conditions
□	□	Purple striae
□	□	Steroid treatments
□	□	Testosterone deficiency
□	□	Thyroid problems

Head and Ear, Nose and Throat

Past	Current	
□	□	Blurred or double vision
□	□	Cataracts
□	□	Chronic ear infections
□	□	Dental problems
□	□	Difficulty swallowing
□	□	Ear or hearing problems
□	□	Earache
□	□	Eye or vision problems
□	□	Eye surgery
□	□	Eyeglasses or contact lenses
□	□	Glaucoma
□	□	Gum problems
□	□	Headaches or migraines
□	□	Hoarseness
□	□	Nose congestion or sinus trouble
□	□	Postnasal drip
□	□	Ringing in the ears
□	□	Sore throat
□	□	Swollen lymph nodes

Gastrointestinal

Past	Current	
□	□	Abdominal pain
□	□	Black or bloody stool
□	□	Bloating
□	□	Changes in bowel habits
□	□	Colitis
□	□	Colon cancer or polyps
□	□	Constipation
□	□	Crohn's
□	□	Food sensitivities
□	□	Gastric reflux
□	□	Heartburn
□	□	Hemorrhoids
□	□	IBS
□	□	Jaundice
□	□	Liver disease
□	□	Nausea or vomiting
□	□	Pancreatitis
□	□	Severe diarrhea
□	□	Ulcer

Respiratory

Past	Current	
□	□	Apnea
□	□	Asthma
□	□	Blood in sputum
□	□	Emphysema
□	□	Hay fever
□	□	Persistent cough
□	□	Pneumonia
□	□	Shortness of breath
□	□	Snoring issues
□	□	Tuberculosis
□	□	Wheezing

Cardiovascular

Past	Current	
□	□	Blood clots
□	□	Chest pain or tightness
□	□	Congenital heart defects
□	□	Coronary artery disease
□	□	Dizziness
□	□	Dyspnea
□	□	Excessive bruising
□	□	Heart attack
□	□	Heart murmur
□	□	High blood pressure
□	□	High cholesterol
□	□	Leg pain with walking
□	□	Low blood pressure
□	□	Lower extremity swelling
□	□	Palpitations
□	□	Rheumatic fever
□	□	Varicose veins

Dermatology

Past	Current	
□	□	Change in hair or nails
□	□	Eczema
□	□	Excessive acne
□	□	Excessive hair loss
□	□	Flushing
□	□	Hyper/hypo pigmentation
□	□	Psoriasis
□	□	Skin cancer
□	□	Skin troubles or rashes

2) List and date any past surgeries and/or hospitalizations If NO past surgeries/hospitalizations are known, check here ☐ _____

_____

3) List and date any known fracture, sprains, strains, major trauma/injury: If NO trauma/injuries are known, check here ☐ _____

_____

4) List any known allergies to medications, foods, seasonal, or otherwise. If NO allergies are known, check here ☐ _____

_____

Apex Sports Medicine, 2303 S. Bagdad Rd. #200 Leander, Tx. 78641 Phone: 512-528-6009 Fax: 512-528-3690

5) List current medications, including frequency and dosage if known. **If there are NO current medications, check here** ☐

Name of medication/supplement	Dosage/Start Date		
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

FAMILY HISTORY

1) Check all conditions that run in your biological family: If NO conditions are known, check here ☐

Condition	Relationship to patient	Condition	Relationship to patient
☐ Cancer Type: _____		☐ Genetic Disorder Type: _____	
☐ High Blood Pressure		☐ Heart problems/Stroke	
☐ Anemia		☐ Rheumatoid Arthritis	
☐ Diabetes Type 1		☐ Other _____	
☐ Diabetes Type 2			

SOCIAL HISTORY

1) Do you exercise? ☐ Yes ☐ No **Times per week?** _____ **Intensity?** ☐ Light ☐ Moderate ☐ Strenuous **Type?** _____

2) Do you currently smoke? ☐ Yes ☐ Former smoker ☐ Never been a smoker

If "Yes", how often do you smoke: ☐ Current every day smoker ☐ Current sometimes smoker

If "Yes", what is your level of interest in quitting smoking? ☐ No interest ☐ Moderate interest ☐ High interest

3) Do you drink alcohol? ☐ Yes ☐ No **How many drinks per week?** _____ **For how many years?** _____

4) Do you drink caffeine? ☐ Yes ☐ No **How many drinks per day?** _____

What type? ☐ Coffee ☐ Tea ☐ Soft Drinks ☐ Energy Drinks

5) What do your work duties include? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Other: _____

6) Please describe your overall health right now? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

7) What is your current stress level? ☐ Mild ☐ Moderate ☐ High

8) Please check the types of providers that you have seen in the past:

☐ Chiropractor ☐ Acupuncturist ☐ Massage Therapist ☐ Physical Therapist

9) What are your hobbies? _____

10) Is there any other information you would like to share? _____

_____

FEMALES

Currently Pregnant? ☐ Yes ☐ No ☐ Unsure **If pregnant: When is your due date?** _____

Name of OBGYN:_____ **When was your last OBGYN appointment?** _____

Painful/Abnormal Menstrual Cycle? ☐ Yes ☐ No **Peri/Menopause?** ☐ Yes ☐ No ☐ Unsure

Miscarriage? ☐ Yes ☐ No **Have you given birth?** ☐ Yes ☐ No **If "Yes",** type of birth? ☐ Vaginal ☐ C-Section

Duration of Bleeding:_____ Duration of Cycle:_____ Date of last menses:_____

PATIENT SIGNATURE

By my signature below, I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member at Apex Sports Medicine responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient Name Name of Parent or Legal Guardian (if minor)

x_____ _____

Signature of Patient, Parent or Legal Guardian (if minor) Date

Apex Sports Medicine, 2303 S. Bagdad Rd. #200 Leander, Tx. 78641 Phone: 512-528-6009 Fax: 512-528-3690

Doctor/Practitioner use only:

Apex Sports Medicine, 2303 S. Bagdad Rd. #200 Leander, Tx. 78641 Phone: 512-528-6009 Fax: 512-528-3690