



888 S. Craycroft Road, Suite 100, Tucson, AZ 85711 (520) 298-4999  
Dr. Scott DeMent, D.C. and Dr. Melody DeMent, D.C.

**PLEASE PRINT AND COMPLETE ALL THE QUESTIONS. DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Title: Mr./Mrs./Ms./Miss/Dr./Prof./Rev./other \_\_\_\_\_ Nickname: \_\_\_\_\_

First: \_\_\_\_\_ Middle: \_\_\_\_\_

Last: \_\_\_\_\_ Suffix: \_\_\_\_\_

Current address:

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Primary phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Secondary phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Mobile Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Home Email: \_\_\_\_\_

Work Email: \_\_\_\_\_

Preferred contact method:  Primary phone  Secondary Phone  Mobile  
 Home e-mail  Work e-mail

In which format do you prefer appointment reminders?

Text message  Phone call  E-mail (above)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Sex:  Male  Female

Marital status:  Single  Married  Other

Spouse: \_\_\_\_\_

# of children: \_\_\_\_ Ages of children: \_\_\_\_

Race: (not mandatory)

- White
- Black/African American
- Hispanic
- American Indian or Alaska Native
- Other

Employment Status:

- Employed  Self-Employed
- FT-student
- PT-student
- Other

Preferred Language: \_\_\_\_\_

Employer: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

or did you hear about us from?:  Website/Internet  Newspaper  Event \_\_\_\_\_  
 Window display

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Emergency contact is your:  Spouse/partner  Parent  Other: \_\_\_\_\_

\*\*\*\*\*

Please check any and all insurance coverage that may be applicable in this case:

- Major Medical  Worker's Compensation  Medicaid  Medicare  Auto Accident
- Medical Savings Account & Flex Plans  Other

Name of Primary Insurance Company:

Name of Secondary Insurance Company (if any):

Staff Initials: \_\_\_\_\_

Scott DeMent, D.C. \_\_\_\_\_

Melody DeMent, D.C. \_\_\_\_\_



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Patient Name: \_\_\_\_\_

**Tell Us Why You are Here**

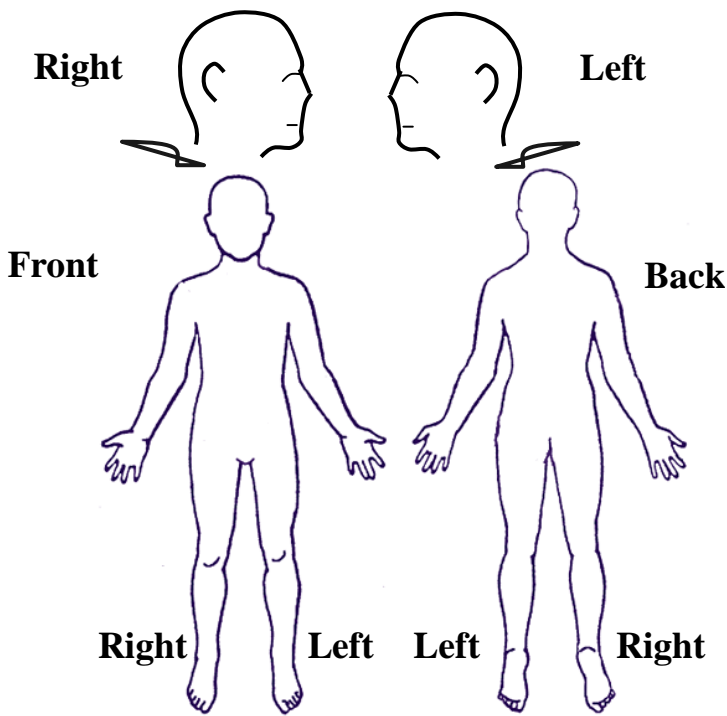
What is the primary reason for your visit? \_\_\_\_\_

Is this due to a:  Automobile accident  Work-related injury  Personal injury case  N/A

When did your pain/symptoms begin (include date if possible)? \_\_\_\_\_

**SUBJECTIVE PAIN ASSESSMENT**

**RATE YOUR PAIN**



Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:  
A=Ache  
B=Burning  
ST=Stabbing  
SP=Spasm  
N=Numbness  
P=Pins and Needles  
T=Throbbing  
SF=Stiffness  
SW=Swelling  
W=Weakness  
  
(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

**PAIN SCALE:** Please circle the number that best describes your overall pain:

0    1    2    3    4    5    6    7    8    9    10    10+  
NONE            LITTLE            MEDIUM            SEVERE            EXCRUCIATING

Are any of the following activities difficult to carry out due to your present condition?:

- Driving a car                       Caring for pets                       Carrying groceries                       Washing dishes
- Sewing or crafts                       Ironing/Cooking                       Doing laundry                       Shaving/brushing teeth
- Gardening/yard work                       Making beds                       Vacuuming                       In/out of bathtub
- Playing with kids/grandkids                       Hobbies/Sports \_\_\_\_\_

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None apply

Other: \_\_\_\_\_



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### FAMILY HISTORY

Please review the diseases and conditions listed below and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTER(S) Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble or Stroke						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Rheumatoid Arthritis						
Scoliosis						
Sinus Trouble						
Spina bifida						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

Staff Initials: \_\_\_\_\_

Scott DeMent, D.C. \_\_\_\_\_

Melody DeMent, D.C. \_\_\_\_\_



Patient Name: \_\_\_\_\_

**Review of Systems**

Please mark whether you had in the **PAST** or **NOW** have any of the following conditions/illnesses:

<b>Past</b>	<b>Now</b>	<b>General</b>	<b>Past</b>	<b>Now</b>	<b>General Gastro-Intestinal</b>
		Fatigue or Weakness			Abdominal Pain
		Night Sweats			Indigestion / Upset Stomach
		Unexpected Weight Change			Excess Gas
		Jaw Pain/TMJ			Heartburn
		Sleeping Problems			Constipation
		Loss of Balance			Diarrhea
		Dizziness or Lightheadedness			Nausea or Vomiting
		Vertigo	<b>Past</b>	<b>Now</b>	<b>Genito-Urinary</b>
		Fainting			Bed Wetting
		Headaches			Urinary Pain or Frequency
		Seizures			Kidney or Bladder Trouble
		Loss of Memory			Blood in Urine or Stool
		Excessive Thirst			Menstrual Problems or Pain
		Thyroid Trouble			Prostate Trouble
		Anxiety or Nervousness			Erectile Dysfunction
		Mood Swings or Irritability			Fertility Problems
		Mental or Emotional Difficulty	<b>Past</b>	<b>Now</b>	<b>Musculoskeletal</b>
		Depression			Arthritis
<b>Past</b>	<b>Now</b>	<b>Eyes, Ears, Nose &amp; Throat</b>			Bone Fracture
		Vision Trouble			Dislocated Joints
		Hearing Trouble	<b>Past</b>	<b>Now</b>	<b>General Cardio-Vascular</b>
		Ear Infections			Chest Pain or Pressure
		ringing or Buzzing in Ears			Heart Trouble/Stroke/Aneurysm/BloodClot
		Loss of Smell			High Blood Pressure/Low Blood Pressure
		Loss of Taste			Cold Hands or Feet
		Difficulty Swallowing			Pacemaker
		Difficulty Speaking	<b>Past</b>	<b>Now</b>	<b>Other Health Conditions</b>
		Sinus Trouble			Autoimmune Disease Type: _____
<b>Past</b>	<b>Now</b>	<b>Skin</b>			Cancer Type: _____
		Skin Problems			Diabetes/Hypoglycemia
<b>Past</b>	<b>Now</b>	<b>Respiratory</b>			Fibromyalgia
		Asthma			Multiple Sclerosis
		Wheezing			Rheumatic Fever
		Chronic Cough			Tuberculosis
		Shortness of Breath			<b>Other:</b> _____
					Poor healing/healing disorder
					No Conditions/Illnesses



Patient Name: \_\_\_\_\_

YES	NO	<i>Please answer the following questions:</i>
		Do you get dizzy or get a headache when you look up or twist your head? If yes, how often:
		Do you have neck pain that sends pain downwards between your shoulders or to the front of your chest?
		Have you had a new type of headache or an unusually severe headache recently?
		Have you noticed your head leaning or tilting to one side recently?
		Do you have pain that shoots or radiates outward along your rib cage?
		Does your middle back or chest wall pain intensify when you take a deep breath or cough?
		Do you have a tight band-like feeling sometimes around your chest?
		Have you recently had any associated unusual indigestion, chest pressure, pain down your left arm or unusual jaw pain?
		When you move your neck around, does your middle back or chest pain increase?
		When you cough, sneeze, or bear down to have a bowel movement, does your back/leg pain get worse?
		Do you have a consistent pattern of getting severe leg pain or cramping after walking for similar distances that is relieved by resting or sitting down? The pain resumes after walking for the same distance.
		Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down? This pain doesn't bother you at night or while sitting.
		Does either leg or foot drag on the floor when you walk?
		Have you had a lot of leg cramps at night recently?
		Have you recently had any urinary or bowel incontinence or had difficulty urinating?
		Do your feet feel cold recently? If yes, indicate which foot or if both feet:
		Have you recently noticed that either of your legs occasionally gives out on you when you walk?
		Does one or both of your legs feel weak recently?
		Has your anal-rectal region been completely numb?

***Many of the following questions are now mandated by the government for the Electronic Health Records Regulation. Thank you for your understanding.***

Which is your dominant hand:  Left  Right  Ambidextrous

List any **allergies**: \_\_\_\_\_

List any **allergies to medicine**: \_\_\_\_\_

**Past Surgeries and Hospitalizations** (please include implants such as breast implants):



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List any **prescription/over-the-counter** medication (we would be happy to copy a list if you have one):

**DRUG**

**CONDITION**

_____	_____
_____	_____
_____	_____
_____	_____

Have you taken any pain medication today? If yes, describe: \_\_\_\_\_

List any **vitamins** and **supplements**:

**NUTRITIONAL SUPPLEMENT**

**CONDITION**

_____	_____
_____	_____

**Occupation**

Job description: \_\_\_\_\_ Work schedule: \_\_\_\_\_

How often does your job involve lifting?  Never  Occasionally  Frequently  Constantly

Physical stress level:  Low  Medium  High

Other job requirements (please check all that apply):  Bending  Carrying  Stooping  
 Twisting  Turning  Walking  Other:

What is your primary work position?  Seated  Standing  Other: \_\_\_\_\_

Have you been injured on the job?:  Yes Past/Present  No

**Recreation**

List the recreational activities that you like to do: \_\_\_\_\_

Frequency: \_\_\_\_\_ Physical difficulty: 0 1 2 3 4 5 6 7 8 9 10

**Your Lifestyle**

Do you smoke?  No  Yes; Years smoked: \_\_\_\_\_ # Packs per day: \_\_\_\_\_

Interest in quitting: 0 (none) 1 2 3 4 5 6 7 8 9 10 (very interested)

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How many alcoholic drinks do you consume per week?	
How much coffee or caffeinated drinks do you consume per day?	
How much soda do you consume per day?	
How much water do you consume per day?	
How many of hours per night do you sleep?	
How often do you take pain relievers?	
How often do you use recreational drugs?	

Rank how healthy your eating habits are:

(junk food only) 0 1 2 3 4 5 6 7 8 9 10 (healthy food only)

Do you exercise?  No  Yes—How often: \_\_\_\_\_

Describe your physical stress level:  None  Minimal  Moderate  Extreme

Describe your emotional stress level:  None  Minimal  Moderate  Extreme

Do you have weight issues?  No  Yes- Would you like help?  No  Yes

How would you rate your overall health? (awful) 0 1 2 3 4 5 6 7 8 9 10 (amazing)

Is there anything else you would like us to know?  No  Yes: \_\_\_\_\_

Is there any reason why you might have trouble lying face down on an examination table? If yes, why:  
\_\_\_\_\_

**WOMEN ONLY:** To your knowledge are you pregnant?  No  Yes Due date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Other Health Care Providers**

Have you ever been to a doctor of chiropractic before?  No  Yes How long ago? \_\_\_\_\_

Name of previous chiropractor: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

List reason: \_\_\_\_\_

Do you see a medical doctor or osteopath?  No  Yes List date of last visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of medical doctor: \_\_\_\_\_ City/State: \_\_\_\_\_

**PROFESSIONAL COURTESY:** By my signature below, I request and authorize DeMent Family Chiropractic to provide my medical doctor with a report for my medical record. Please send to:

Name of Medical Doctor : \_\_\_\_\_ Office Name: \_\_\_\_\_

Office Address: \_\_\_\_\_ Telephone : (\_\_\_\_) \_\_\_\_ - \_\_\_\_

\_\_\_\_\_

Patient Name (Please Print) : \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Staff Initials: \_\_\_\_\_

Scott DeMent, D.C. \_\_\_\_\_

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Patient Signature : \_\_\_\_\_



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**AUTHORIZATION TO RELEASE INFORMATION:** DeMent Family Chiropractic is authorized to release any information that it deems appropriate concerning my physical condition to any insurance company, personal physicians, other healthcare providers, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by DeMent Family Chiropractic. This also includes its designated associates and assistants. I also hereby release DeMent Family Chiropractic from any consequence and/or liability concerning the same.

**HIPAA:** I understand and agree to allow this chiropractic office to use my Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. I understand that this office wants me to understand how my Patient Health Information is going to be used in this office and my rights concerning those records. If I would like to have a more detailed account of their policies and procedures concerning the privacy of my Patient Health Information I understand that I can read or request a copy of the HIPAA NOTICE that is available to me at the front desk or on their website ([www.tucsonchiropractors.com](http://www.tucsonchiropractors.com)) before signing this consent. The following person(s) have my permission to receive my personal health information:

\_\_\_\_\_  
**PAYMENT:** I understand and agree that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I also understand that consultations are complementary but exams, x-rays and treatment procedures must be paid for on the day that the services are rendered unless a written agreement has been made prior to those services being rendered. **INTEREST AND COLLECTION:** I acknowledge and agree that, should my account become more than thirty (30) days overdue and I have not made a financial agreement with the office, I will incur interest on my past due balance of eighteen percent (18%) per annum. I further acknowledge and agree that DeMent Family Chiropractic shall be entitled to reimbursement from me for any legal costs, including attorney fees, for all efforts to collect on any past due accounts with DeMent Family Chiropractic.

**CONSENT TO CARE FOR A MINOR:** I hereby authorize DeMent Chiropractic to administer care as deemed necessary to: \_\_\_\_\_

**MISSED APPOINTMENTS:** I understand that it is important to keep all of my scheduled appointments in order to receive the best results. However, if I absolutely must cancel an appointment, I must provide 24 hour's notice so that the time slot can be provided to another patient. I also need to reschedule that appointment. I understand that I can be charged \$15 for a missed appointment that is not cancelled prior to 24 hours.

**PATIENT RECORDS:** I understand that I may request my records and x-rays from DeMent Family Chiropractic and that it can take up to 10 business days for the records to be available.

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be detrimental to my health. It is my responsibility to inform DeMent Family Chiropractic of any changes in my health status. By my signature below, I understand and agree to the above policies, procedures, authorizations and agreements.

\_\_\_\_\_  
Patient Name (Please Print) Patient Signature Date

\_\_\_\_\_  
Guardian Name (Please Print) Guardian Signature Date