



Confidential Patient Information

Welcome

Please Print

Acct# _____

We want to get to know you and appreciate you filling in our forms!

Name _____ Address _____

City _____ State _____ Zip Code _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: M F Marital Status: M S D W

Email Address: _____

Social Security #: _____ Primary Care Physician (name/facility): _____

Females; are you pregnant? Y N Date of Last Menstrual Cycle: _____

Have you ever received chiropractic care in the past? Y N Last Date Treated: _____

Whom may we thank for referring you to our office? _____

Employer

Occupation: _____ Employer: _____

Employer Address _____ City _____ State _____ Zip Code _____ Employer Phone _____

Spouse

Spouse's Name _____ Spouse's Employer _____ Occupation _____

Children and Ages: _____

Emergency Contact

Name _____ Address _____

City _____ State _____ Zip Code _____

Contact phone: _____ Cell Phone: _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I authorized the release of any medical information necessary to process this claim and authorize payment of services to this office. I understand any amount paid directly to the office will be credited to my account. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I will make payment for my portion of charges at each visit unless other arrangements are made.

Patient's Signature: _____ Date: _____
(signature of parent or guardian if the patient is a minor)

Symptoms

1. What is your number-one problem or the one area of greatest pain? _____

2. Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain.
0 1 2 3 4 5 6 7 8 9 10

3. When did this problem/pain start? _____ Gradual Sudden Progressive

4. What do you think caused this problem? _____

5. How often do you experience the pain?
 1-2 hours per day About half of the day Most of the day The pain never goes away

6. How often does the pain affect your daily activities?
 It does not affect my daily activities I have had to change how I do things
 I have had to stop doing some of my daily activities I am unable to perform daily activities

7. What increases your pain? _____

8. What decreases your pain? _____

9. Have you ever experienced this problem before? Y N When? _____

10. List any other complaints currently bothering you and rate your pain level for each using the same scale as above.
a) _____ 0 1 2 3 4 5 6 7 8 9 10
b) _____ 0 1 2 3 4 5 6 7 8 9 10
c) _____ 0 1 2 3 4 5 6 7 8 9 10
d) _____ 0 1 2 3 4 5 6 7 8 9 10

11. Have you ever been involved in an automobile accident? Y N
a) If yes, when? _____
b) Were you injured? Y N Please explain: _____

12. Have you ever been injured at work? Y N
a) If yes, when? _____
b) Please explain: _____

13. List all medication you are currently taking (*prescribed and over the counter*) _____

14. List all surgeries you have had (*with date*) _____

If you have experienced any of the following conditions in the past, mark a "P" on the line provided. If you are currently experiencing any of the following conditions, please mark a "C" on the line provided. (check all that apply)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> heart attack | <input type="checkbox"/> stroke | <input type="checkbox"/> bloody stools | <input type="checkbox"/> asthma |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> glaucoma | <input type="checkbox"/> cancer | <input type="checkbox"/> menstrual cramping |
| <input type="checkbox"/> difficulty with urination | <input type="checkbox"/> anemia | <input type="checkbox"/> diverticulosis | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> prostate trouble | <input type="checkbox"/> ulcers | <input type="checkbox"/> chest pain | <input type="checkbox"/> sudden weight loss |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> loss of memory | <input type="checkbox"/> general fatigue | <input type="checkbox"/> tobacco use |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> diarrhea | <input type="checkbox"/> soreness in joints | <input type="checkbox"/> loss of hearing |
| <input type="checkbox"/> constipation | <input type="checkbox"/> muscle cramping | <input type="checkbox"/> migraine | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> nausea | <input type="checkbox"/> headache | <input type="checkbox"/> syphilis | <input type="checkbox"/> sprained ankle |
| <input type="checkbox"/> ears ringing | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> gall bladder trouble | <input type="radio"/> R <input type="radio"/> L |
| <input type="checkbox"/> gout | <input type="checkbox"/> arthritis | <input type="checkbox"/> kidney stones | |
| <input type="checkbox"/> knee/hip replacement | <input type="checkbox"/> fainting spells | <input type="checkbox"/> difficulty w/bowel movements | |
| <input type="checkbox"/> broken bones (specify) _____ | | | |

General Activities (check all that apply)

- | | |
|---|--|
| <input type="radio"/> sleep on waterbed | <input type="radio"/> play video games (___ hrs per day) |
| <input type="radio"/> read in bed | <input type="radio"/> exercise ___ x/wk. |
| <input type="radio"/> fall asleep in recliner / on couch | <input type="radio"/> jog ___x/wk. |
| <input type="radio"/> sleep on stomach | <input type="radio"/> computer use (___ hrs per day) |
| <input type="radio"/> needlepoint/ knitting | <input type="radio"/> swim |
| <input type="radio"/> use two or more pillows to sleep with | <input type="radio"/> use treadmill / elliptical mach. |
| <input type="radio"/> sewing | <input type="radio"/> watch television (___ hrs per day) |
| <input type="radio"/> lift weights / wt. mach. | |

Please add anything else you would like the doctor to know: _____

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____
(signature of parent if the patient is a minor)

Date _____

Doctor's Comments: _____

Body Diagram Date _____

Acct# _____

Last Name _____

First Name _____

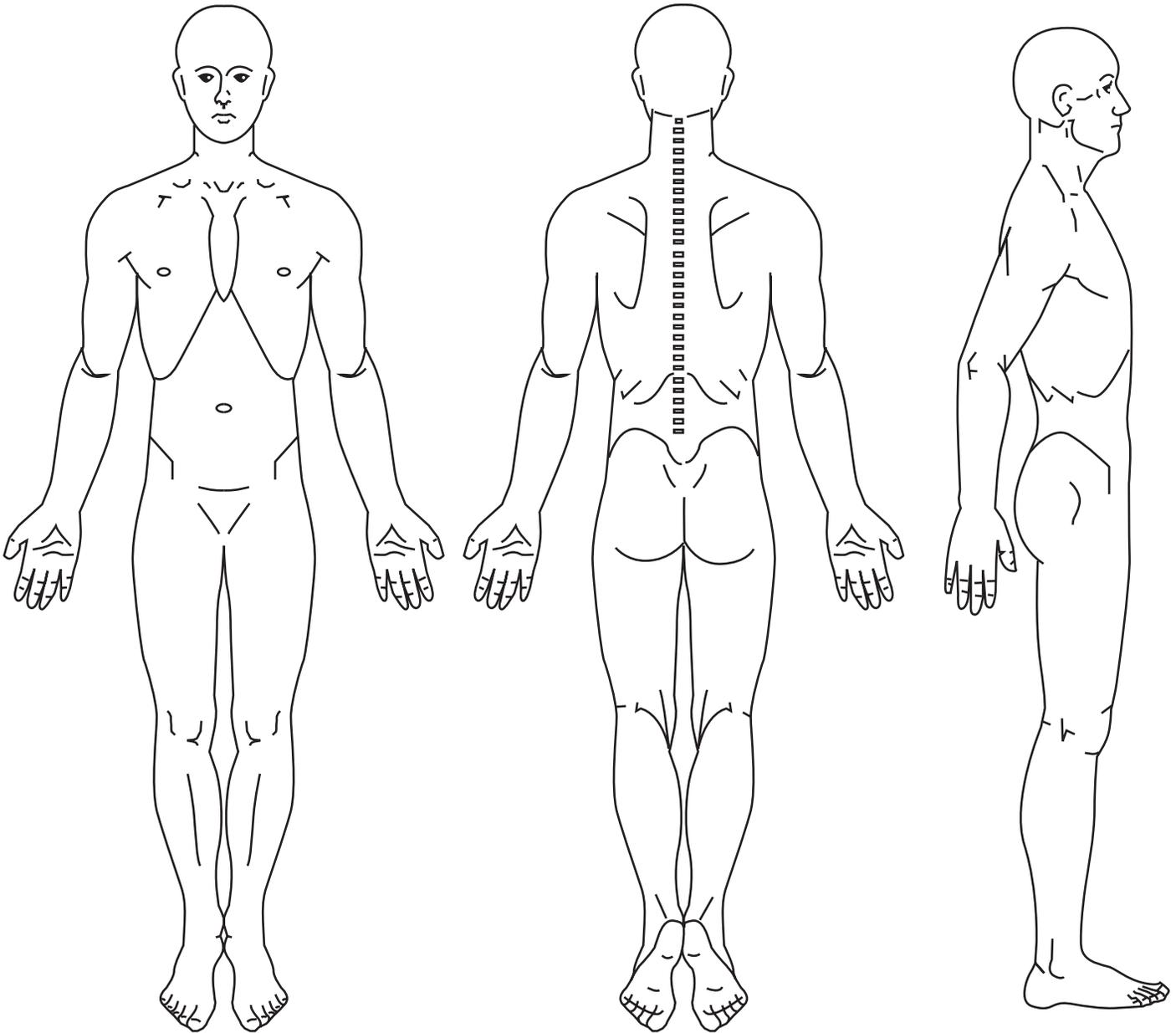
Please mark the diagrams according to where you experience your symptoms and pain using the following symbols:

X for Sharp Pain

O Dull Ache

/// Burning Pain

******* Numbness



Patient's Signature _____

Date _____