



Patient Information

(Please Print) Please provide a form of identification and health insurance card (if applicable) to the front office staff.

Name _____ Date: _____ SSN: _____ - _____ - _____ Age _____
First MI Last City State Zip

Sex: Female Male Height: _____ Weight: _____ E-mail Address _____

Birth Date _____ Are you: Minor Single Married Divorced Widowed Separated

Home phone # _____ Work phone # _____ Cell phone # _____

Do you prefer to receive calls at: Home Work Cell

Your employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's or parents name _____ Workplace _____ Work phone # _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

Responsible Party

Name of person responsible for this account? _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work phone # _____

Symptoms

Reason for visit _____ When did you first notice the symptoms? _____

Is this condition getting progressively worse? _____

Where specifically is the problem located? _____

Which activities are difficult to perform? Sitting Standing Walking Bending Lying down Other

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling Other

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition?

Medication Surgery Physical Therapy Other

Name and address of other doctor(s) who have treated you for your condition: _____

Daily Habits:

What type of exercise do you perform on a daily basis? None Moderate Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work) _____

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

Do you smoke? No Yes How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Health History

Check only those conditions with are applicable:

- | | | |
|----------------------------------------------|---------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Spinal Surgery | <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Fractures | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Spinal Fracture | <input type="checkbox"/> Goiter | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Hernia | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Measles | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Other injuries or illness |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps | |

Other injuries or illness: _____

Dates of last exams _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

List any types of surgeries which you have had and the dates which they occurred: _____

Please list all medications you are currently taking: _____

Allergies: _____

Previous Chiropractic treatment: Name of Doctor _____

Reason for care: _____

When was care rendered? _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor 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 and pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic 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.

X _____
SIGNATURE OF PATIENT (or parent if a minor) DATE

X _____
PRINT PATIENT NAME