

PATIENT INFORMATION

Thank you for choosing our practice for your chiropractic needs.

Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.



(PLEASE PRINT)

Name _____ Date _____
FIRST MIDDLE INITIAL LAST

Social Security # _____

Address _____ City _____ State _____ Zip _____

Sex: Female Male Birth Date _____ E-mail _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Do you prefer to receive calls at: Home Work Cell No Preference

Married Widowed Single Partnered Minor Separated Divorced

Patient's Employer/School _____ Occupation _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's name _____ Employer _____ Work Phone (____) _____

Who 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 (____) _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birth Date _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone (____) _____

Insurance ID # _____ Group # _____

DO YOU HAVE ADDITIONAL INSURANCE? No Yes

IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birth Date _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone (____) _____

Insurance ID# _____ Group # _____

SYMPTOMS

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

Is this condition getting progressively worse? _____

Where specifically is the problem(s) 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: _____

HEALTH HISTORY *(Check only those conditions which are applicable)*

- | | | | | | |
|-----------------------|-------------|------------------|---------------------|----------------------|-----------------|
| AIDS/HIV | Bulimia | Goiter | Measles | Polio | Tumors, Growths |
| Alcoholism | Cancer | Gonorrhea | Migraine Headaches | Prostate Problems | Typhoid Fever |
| Allergy Shots | Cataracts | Gout | Miscarriage | Prosthesis | Ulcers |
| Anemia | Addictions | Heart Disease | Mononucleosis | Psychiatric Care | Whooping Cough |
| Anorexia | Chicken Pox | Hepatitis | Multiple Sclerosis | Rheumatoid Arthritis | Other _____ |
| Arthritis | Depression | Hernia | Mumps | Scarlet Fever | _____ |
| Asthma | Diabetes | Herniated Disc | Osteoporosis | Stroke | _____ |
| Bleeding Disorders | Emphysema | Herpes | Pacemaker | STD's | _____ |
| Blood Pressure H or L | Epilepsy | High Cholesterol | Parkinson's Disease | Thyroid Problem | _____ |
| Breast Lump | Fractures | Kidney Disease | Pinched Nerve | Tonsillitis | _____ |
| Bronchitis | Glaucoma | Liver Disease | Pneumonia | Tuberculosis | _____ |

(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 on which they occurred: _____

Please list all medications you are currently taking _____

Allergies _____

DAILY HABITS

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

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

What vitamins or supplements do you currently take? _____

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? _____

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility ' to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

SIGNATURE OF PATIENT PARENT GUARDIAN OR PERSONAL REPRESENTATIVE

DATE

SIGNATURE OF PATIENT PARENT GUARDIAN OR PERSONAL REPRESENTATIVE

RELATIONSHIP TO PATIENT