PATIENT INFORMATION

Date: _____ / _____ / _____

Name: _____ Preferred Name: _____

DOB: _____ / _____ / _____ Age: _____ Male Female Email Address: _____

Address: _____ City, State, Zip: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Status: Minor Single Married Other: _____ Spouse's Name: _____

Do you have children? Yes No If yes, how many? _____

Have you seen a chiropractor before? Yes No Clinic/Doctor's Name: _____

Whom may we thank for referring you today? _____

Emergency Contact

Name: _____ Relation: _____ Phone: _____

Employment Information

Employer Name: _____ Occupation: _____ How long? _____

Address: _____ City, State, Zip: _____

Primary Insurance

Insurance Co.: _____ Subscriber ID: _____

Insured's Name: _____ Insured's Name: _____

Relation: _____ DOB: _____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company

Current Patient Condition

Reason for today's visit: _____ Emergency _____ New injury _____ Old injury _____ Chronic pain ____ Wellness

Are you in pain? _____ Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense

Type of pain: ___ Sharp ___Dull ___ Throbbing ___Numbness ___Aching ___Shooting ___Burning ___ Tingling ___Cramps ___Stiffness ___Swelling Other _____

Where did your injury occur? _____ Work _____ Sports/Play _____ Auto Accident ____ Routine/Household Activity

When did your condition/accident occur? _____ Where? _____

Please explain what happened:

_____

_____

Is condition interfering with: _____ Work _____ Sleep or _____ Daily routine? If so, how: _____

Has this or something similar happened in the past? Yes No If Yes, explain: _____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest) 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., family status change, work related, finances, etc..) _____

Do you experience any of these general symptoms EVERYDAY?

__Bleeding	__ Insomnia	__ Fecal incontinence	__Nausea	__ Shortness of breath
__ Headaches	__ Vomiting	__ Urinary incontinence	__Discharge	__ Constipation
__ Dizziness	__ Diarrhea	__ Low Grade Fever	__ Itching/rash	__ Chronic pain/inflammation

MEDICAL HISTORY

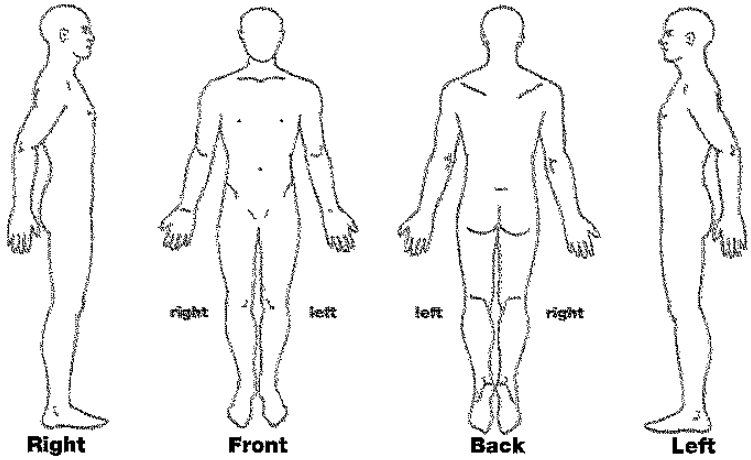
Do you consider yourself: ___ Underweight ___ Overweight ___Just right

Have you had an unintentional weight loss or gain of 10 pounds or more in the last 3 months? ___ Yes ___No

Have you recently thought about doing something about your weight or your body? ___Yes ___No

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)? ___Yes ___No

Using the body chart below, please circle all affected areas.



Are you taking any of the following medications?
Nerve pills _ Painkiller (i.e. Aspirin) _ Muscle Relaxers _
Blood thinners _ Tranquilizers _ Insulin _ Other: _____

Please circle yes (Y) or no (N) on the following:

Y N Difficulty Breathing	Y N Cancer
Y N Chemotherapy	Y N Lower Back Pain
Y N Heart Murmur	Y N Kidney Problems
Y N Shingles	Y N High/Low Blood Pressure
Y N Venereal Disease	Y N Artificial Bones/Joints
Y N HIV/AIDS/ARC	Y N Tuberculosis
Y N Congenital Heart Defect	Y N Emphysema/Asthma
Y N Alcohol/Drug Abuse	Y N Arthritis
Y N Heart Attack/Stroke	Y N Artificial Valves
Y N Frequent Neck Pain	Y N Glaucoma
Y N Rheumatic Fever	Y N Fainting/Seizures/Epilepsy
Y N Hepatitis	Y N Severe/Frequent Headaches
Y N Anemia/Diabetes	Y N Ulcers/Colitis
Y N Psychiatric Problems	Y N Mitral Valve Prolapse
Y N Sinus Problems	Y N Heart Surgery/Pacemaker

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____
_____

List any serious accidents with dates:
_____

Family health history: _____
Take supplements/vitamins? No Yes Do you exercise? No Yes If yes, how often? _____
Is your diet: __Mixed food (animal & veg) __Vegetarian __ Vegan __ Salt restricted __ Fat restricted
__ Carb/starch restricted __ Total calorie restricted __ Specific foods
Do you smoke? No Yes How often? _____ For how long? _____
Do you drink alcohol? No Yes If so, how many drinks per week? _____
Are you wearing: Shoe lifts Inner soles Arch supports
Are you dieting? No Yes Since: _____
For women only: Are you on birth control? No Yes Are you nursing? No Yes
Are you pregnant? No Yes If so, how many weeks? _____
Would you like to: __ Have more energy __Be stronger __ Have more endurance __ Increase sex drive __
__ Be thinner __Be less moody __ Think more clearly __Take less OTC meds (aspirin, etc.) __ Sleep better

❖ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

❖ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

❖ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____