Gillis Chiropractic Clinic
PERSONAL HISTORY

Date _____

Name: _____ Social Security # _____

Address: _____ City: _____ State _____ Zip Code _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Birthdate: _____ Age: _____ Sex: _____ Height/Weight: _____

Name of your Employer: _____ Type of Work: _____

Type of Insurance: _____ Marital Status: _____ Name of Spouse: _____

Spouse's Employer: _____ Spouse's Social Security # _____

Type of Insurance: _____ Are you covered by this insurance? _____

Name and Phone Number of Nearest Relative (outside of your home): _____

Who is responsible for your bill? ❑ Insurance ❑ Workman's Compensation ❑ Medicaid ❑ Self
❑ Auto Insurance ❑ Medicare ❑ Other _____

Referred by: ❑ TV ❑ Yellow Pages ❑ Previous Patient ❑ Friend _____ ❑ Other _____

PAST HEALTH HISTORY

OPERATIONS: (Spinal or Joint) _____

_____

ACCIDENTS OR FALLS: (Please describe) _____

_____

_____

FRACTURES OR DISLOCATIONS: _____

_____

HABITS:

Sleep (hours) _____ Coffee _____ Alcohol _____ Exercise _____ Tea _____ Tobacco _____

Are you now taking any medications? (Please explain for what) _____

_____

Are you pregnant? ❑ Yes ❑ No

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 Gillis Chiropractic to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such chiropractic care to third payers and/or health practitioners. I authorize and request my insurance company to pay directly to Gillis Chiropractic or chiropractic group insurance benefits otherwise payable to me. A fee schedule is available upon request. 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.

_____ _____

Patient Signature Date

Name_____ **Date of Birth**_____ **Date**_____

WHEN DID SYMPTOMS APPEAR?_____

WAS THIS WORK OR AUTO RELATED?_____

HOW DID SYMPTOMS OCCUR?_____

_____

_____

_____

SYMPTOMS

Please Circle All the Following Symptoms you have (now.)

Please Underline All the Following Symptoms you have had previously.

Headaches	Pins/Needles in Legs, Feet, Toes	Sinus Trouble
Neck Pain	Numbness in Legs, Feet, Toes	Difficult Breathing
Stiff Neck	Pain in Legs, Feet, Toes	Stomach Pains
Fainting/Dizziness	Chest Pain/Previous Heart Attack	Joint Swelling
Pins/Needles in Arms, Hands, Fingers	High Blood Pressure/Low Blood Pressure	Constipation/Diarrhea
Numbness in Arms, Hands, Fingers	Pain Between Shoulder Blades	Faulty Posture
Pain in Arms, Hands, Fingers	Shoulder Pain	Spinal Curvature
Mid Back Pain	Elbow Pain	Painful Urination
Low Back Pain	Asthma	Epilepsy
Hip Pain	Frequent Colds	Cancer

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

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

Are you presently being treated for any other condition? ❑ Yes ❑ No If yes, what?_____

_____ By who? _____

Have you ever had prior Chiropractic Care? ❑ Yes ❑ No If yes, who? _____

(For Doctor's Use Only)

ONSET: _____

ETIOLOGY: _____

HX of BP: _____

PRIOR TX: _____

Doctor's Notes: _____

D/TRIAD: _____

HEEL/TOE WALK: _____