Welcome to Fletcher Chiropractic Office

1 PATIENT INFORMATION

Date_____ SSN_____

Name_____
First

_____
Last Middle Initial

Address_____

City_____

State_____ Zip_____

Birthdate_____ Age_____ Sex ☐ Male ☐ Female

E-Mail_____

Providing your e-mail allows our office to send correspondence electronically such as health records, billing statements, appointment reminders, newsletters, etc.

Home Phone (____)_____Cell Phone (____)_____

Work Phone (____)_____ Employer_____

Emergency Contact_____

Emergency Phone (____)_____Relationship_____

Preferred Language_____Race_____

☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse's Name_____

Birthdate_____ Spouse's SSN_____

Spouse's Employer_____

Spouse's E-mail_____

Whom may we thank for referring you?_____

2 INSURANCE INFORMATION

Policy Holder_____

Relationship to Patient_____

Insurance Co_____

Policy Number_____

Secondary Insurance_____

Policy Holder_____Birthdate_____

Relationship to patient_____

Assignment and Release

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

_____ and assign directly to
Name of Insurance Company(ies)

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.

_____
Printed Name(s)

_____
Signature(s) (if patient is a minor and both parents are present, then both parents are required to sign)

_____ _____
Date Relationship to Patient

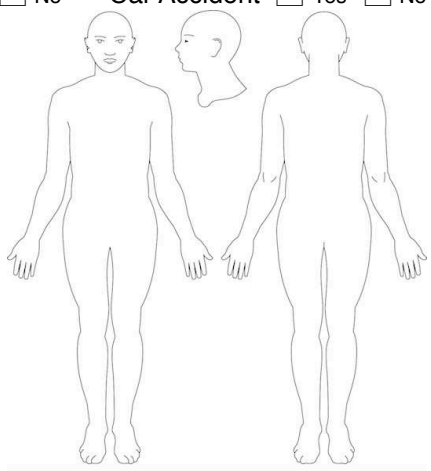
3 PRESENT COMPLAINT(S)

Reason for Visit_____ Worker's Comp ☐ Yes ☐ No Car Accident ☐ Yes ☐ No

When did you notice symptoms? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you are experiencing symptoms.



Rate the severity of pain on a scale from 1 (mild) to 10 (severe)_____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numb ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramping ☐ Stiffness ☐ Swelling ☐ Other

Is it constant or does it come and go? _____

Activities or movements that are painful to perform?_____

-OVER-

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HEALTH HISTORY

What treatment have you already received for this problem? ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other_____

Name of doctor(s) who have treated you for your condition _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

☐ Yes	☐ No	AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Multiple Myeloma	☐ Yes	☐ No	Stroke
☐ Yes	☐ No	Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Suicide Attempt
☐ Yes	☐ No	Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Thyroid Issue
☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tonsillitis
☐ Yes	☐ No	Anorexia	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Parkinson's	☐ Yes	☐ No	Tuberculosis
☐ Yes	☐ No	Appendicitis	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pinched	☐ Yes	☐ No	Tumors/Growths
☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Typhoid Fever
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Ulcers
☐ Yes	☐ No	Bleeding Disorder	☐ Yes	☐ No	Herniated Disc	☐ Yes	☐ No	Prostate Issue	☐ Yes	☐ No	Vaginal Infection
			☐ Yes	☐ No	High Blood	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	Whooping Cough
☐ Yes	☐ No	Breast Lump	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Psychiatric	☐ Other_____		
☐ Yes	☐ No	Bulimia	☐ Yes	☐ No	Kidney	☐ Yes	☐ No	Rheumatoid Arthritis			
☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Liver	☐ Yes	☐ No	Rheumatic Fever			
☐ Yes	☐ No	Cataracts	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever			
☐ Yes	☐ No	Chemical Dependency	☐ Yes	☐ No	Migraines	☐ Yes	☐ No	Sexually Transmitted Disease			

FAMILY HISTORY

Father ☐ Alive ☐ Deceased Died from_____

Mother ☐ Alive ☐ Deceased Died from_____

Siblings ☐ Alive ☐ Deceased Died from_____

Grandparents: Maternal ☐ Alive ☐ Deceased Died from_____

Grandparents: Paternal ☐ Alive ☐ Deceased Died from_____

Other familial disease_____

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

SOCIAL HABITS

- ☐ Tobacco Products
- ☐ Former Smoker
- ☐ Alcohol
- ☐ Coffee/Caffeine Drinks

Packs/Week_____

Quit Date_____

Drinks/Week_____

Cups/Day_____

Are you pregnant? ☐ Yes ☐ No Due Date _____ Have you suffered any miscarriages ☐ Yes ☐ No How Many?_____

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

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MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name		

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NUTRITIONAL/WELLNESS HISTORY

How would you rate your nutrition/diet? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you tried a weight loss program in the past year? ☐ Yes ☐ No Which one?_____

Did you see results with that weight loss program? ☐ Yes ☐ No

How many meals do you eat per day? _____ How many times do you snack in a day? _____

Do you eat at least 1 1/2 cups of fruits/day? ☐ Yes ☐ No Do you eat at least 2 1/2 cups of vegetables/day? ☐ Yes ☐ No

How many times a week do you consume red meat? _____ Fish? _____ Nuts/Beans/Legumes?_____

How much water do you drink/day? _____

How many sodas, sports drinks and/or juices do you drink/week? _____

How many times a day do you go to the bathroom? Urinate_____ Bowel Movements_____

Do you have weight loss, nutritional, or diet goals? ☐ Yes ☐ No What are they? _____

_____

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MENTAL HEALTH HISTORY

How would you rate your current stress level? ☐ Very High ☐ High ☐ Moderate ☐ Low

What is/are the main contributor(s) to your stress? _____

_____

How do you relieve/manage stress? _____

_____

Do you have concerns about your stress levels and need help relieving it? ☐ Yes ☐ No

Do you have a support group or someone you can confide in? ☐ Yes ☐ No

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I WOULD LIKE TO...

Have more energy	☐ Yes ☐ No	Be more organized	☐ Yes ☐ No
Be stronger	☐ Yes ☐ No	Improve memory	☐ Yes ☐ No
Have more endurance	☐ Yes ☐ No	Have more focus and clearer thoughts	☐ Yes ☐ No
Increase your sex drive	☐ Yes ☐ No	Not be dependent on prescription drugs	☐ Yes ☐ No
Be thinner	☐ Yes ☐ No	Not be dependent on over-the-counter drugs	☐ Yes ☐ No
Build more muscle	☐ Yes ☐ No	Stop using laxatives or stool softeners	☐ Yes ☐ No
Improve complexion	☐ Yes ☐ No	Sleep better	☐ Yes ☐ No
Have healthier hair	☐ Yes ☐ No	Get fewer colds and flus	☐ Yes ☐ No
Be less depressed	☐ Yes ☐ No	Have stronger teeth	☐ Yes ☐ No
Feel more motivated	☐ Yes ☐ No	Reduce your risk of chronic disease	☐ Yes ☐ No