Peninsula Chiropractic Center

331 Kentucky St. • Sturgeon Bay, Wi. 54235 • Telephone 920-743-6919 • Fax 920-746-0619

CONFIDENTIAL PATIENT INFORMATION DATE ___________

W/________________ C/___________________

NAME____HOME PHONE__________________

ADDRESS_____________________________ CITY: ______________ ZIP CODE___________

AGE________BIRTH DATE _________________MARITAL: S M SEP W D

HOW MANY CHILDREN____ AGES ______ EMAIL: ____________________________

OCCUPATION____________________________EMPLOYER____________________________

ADDRESS____OFFICE PHONE___________

PATIENT'S NEAREST RELATIVE_____________________________________PHONE__________

WHOM MAY WE THANK FOR REFERRING YOU TO US?_________________________________

HAVE YOU EVER SUFFERED FROM:

1. Dizziness:__________
2. Backaches:__________
3. Heart Trouble:________
4. Diabetes:___________
5. Tuberculosis:________
6. Digestive Disorders:____
7. Arthritis:____________
8. Headaches:__________
9. Numbness: __________
10. Asthma:____________
11. Neuritis:____________
12. Prostate Problems_______
13. Nervousness___________
14. Sinus Trouble:__________
15. Anemia:_______________
16. Rheumatic Fever:________
17. Cancer:_______________
18. Other_________________

HAVE YOU RECEIVED CHIROPRACTIC TREATMENT IN THE PAST?____________

NAME OF DOCTOR ____

WHAT TYPE OF PAIN ARE YOU SUFFERING FROM?____________________________________

____

OTHER DOCTORS SEEN FOR THIS CONDITION____

YOUR CURRENT MEDICAL DOCTOR____

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITION BY A PHYSICIAN IN THE LAST YEAR? ______YES ______NO

DESCRIBE____

WHAT MEDICATIONS OR DRUGS ARE YOU TAKING?___________________________________

(PLEASE TURN THE PAGE OVER TO COMPLETE THIS FORM.)

ARE YOU PREGNANT?________ DATE OF LAST PHYSICAL EXAMINATION__________

WHAT SURGERIES HAVE YOU HAD?____________________

WHEN?________ SERIOUS ILLNESSES?__________ WHEN?______

REMARKS AND ADDITIONAL INFORMATION____________________

____

DOES YOUR INSURANCE COVER CHIROPRACTIC CARE?__________

PAYMENT IS EXPECTED AT TIME OF VISIT!

NAME OF PERSON RESPONSIBLE FOR PAYMENT____________________

SIGNATURE____________________________ DATE__________

SOCIAL SECURITY NUMBER____________________

PARENT, GUARDIAN OR SPOUSE'S AUTHORIZING CARE ____________________

IF THIS APPOINTMENT IS DUE TO AN ACCIDENTAL INJURY PLEASE INFORM THE RECEPTIONIST!!

***TO BE FILLED OUT BY DOCTOR: PATIENT HISTORY

CHIEF COMPLAINT______________________________

____

ONSET____________________________________

PAIN____________________________________

____

EXACERBATED BY______________________________

____

PAST HISTORY______________________________

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