Patterson Chiropractic Clinic
Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION Today's Date: ______________________

Name: ____ Date of Birth: ____________________
Address: ____
City: ____________________________________ State: _________________ Zip: ________________
Home Phone: ________________________________Work Phone: ______________________________
Social Security #: __________________________________ Age: __________ ☐ Male ☐ Female
Your Occupation: ____________________________Your Employer: ___________________________
Name of Spouse or nearest Relative: _________________________Phone: ____________________

Referred to this Office by: ☐ Friend/Family Member – Name? _________________________________
☐ Yellow Pages ☐ Mail ☐ Clinic Location ☐ Other: _______________________________________

Payment fro Services will be by: ☐ Cash ☐ Check ☐ Medicare / Medicaid ☐ Health Insurance
☐ Automobile Insurance ☐ Worker's Compensation

Name of Insurance Company: ____
Insured's Employer: ____
Insured's Social Security #: _________________________ Employer's Phone #: _________________

Are you covered by more than one insurance company? ☐ Yes ☐ No
Name: ____

Have you consulted with an attorney? _______ Name: ______________________________________
Attorney Phone #: ____

MEDICAL/FAMILY HISTORY PLEASE LIST HISTORY OF DISEASE BELOW:

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS: (headaches,neck pain, back pain, etc.)
Please Rate Your symptoms (1-10, with 1 being least serious)

1. ____ __________
2. ____ __________
3. ____ __________
4. ____ __________
5. ____ __________
6. ____ __________

SYMPTOMS ARE WORSE IN ☐ Morning ☐ Afternoon ☐ Night ☐ Consistent

SYMPTOMS DEVELOPED FROM: ☐JOB RELATED INJURY ☐ AUTO ACCIDENT ☐ OTHER ☐ ACCIDENT

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☐ ILLNESS ☐ UNKNOWN CAUSE ☐ GRADUAL ONSET ☐ DATE OCCURRED: _______________

PLEASE DESCRIBE YOUR INJURY:

PLEASE LIST PREVIOUS MEDICAL CONDITIONS AND TREATMENT:

PLEASE LIST TREATMENT AND NAME OF DOCTORS SEEN FOR PRESENT CONDITION:

SYMPTOMS HAVE PERSISTED FOR #____HOUR(S) ____DAY(S) ___WEEK(S) ___ MONTH(S) _____YEAR(S)

SYMPTOMS/COMPLAINTS: ☐ COME & GO ☐ ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: ☐ NO ☐ YES

ARE YOU TAKING ANY MEDICATIONS: ☐ NO ☐ YES

WHAT KIND? ____

ARE YOU PREGNANT: ☐ NO ☐ YES ARE YOU POSSIBLY PREGNANT: ___________

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:
☐ BENDING ☐ REACHING ☐ STRAINING AT STOOL ☐ COUGHING ☐ SITTING ☐ TURNING HEAD
☐ LIFTING ☐ SNEEZING ☐ WALKING ☐ LYING DOWN ☐ STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:
☐ BENDING ☐ SITTING ☐ LIFTING ☐ STANDING ☐ LYING DOWN ☐ TURNING HEAD ☐ REACHING
☐ WALKING

I hereby authorize my insurance benefits to be paid directly to Patterson Chiropractic Clinic. I realize that I am responsible for any non-covered services. I hereby release my medical records to the insurance carrier responsible for payment of my medical bills. If necessary, I may or may not be referred to a facility partially owned by Dr. Patterson.

Patient's Signature: ____ Date: ______________________