Associated Chiropractic
427 West Harding Rd
Springfield, Oh 45504
(937) 399.1159

PATIENT INFORMATION & CONDITION FORM

Today's Date: _____

PATIENT INFORMATION	
Name:	Preferred Language:
Date of Birth:	Marital Status:
SSN:	GENDER: ☐Male ☐Female
Address:	RACE: Decline to specify, American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, White, other Race ETHNICITY: Decline to specify, Hispanic or Latino, Non-Hispanic or Non-Latino
City:	
State & Zipcode:	
Primary Phone: ( )	
Secondary Phone: ( )	
Email:	Do you have health insurance? ☐Yes ☐No
Do you smoke: ☐Yes, start date: ☐No ☐Former	Is your condition related to an automobile accident? ☐Yes ☐No
How many children do you have?	Is your condition related to a work-related accident? ☐Yes ☐ No
Are you a student? ☐No ☐ Full-time ☐Part-time	**SPOUSE INFORMATION**
Do you drink alcohol? ☐No ☐Yes, Drinks/day	Name:
PATIENT EMPLOYMENT INFORMATION	Date of Birth:
Employer:	SSN:
Occupation:	Phone: ( )
Work Phone: ( )	Employer:
WOMEN ONLY: Are you pregnant or is there a possibility you may be pregnant? ☐No ☐Yes ☐Uncertain	

If you are under 18 years of age, who are your legal parents or guardian?

Name & Relationship: _____ Date of Birth: ___/___/___ Phone: (_____) _____
Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None of these

General Information Related to the Condition:
Approximately when did the conditions or symptoms begin to occur? _____ / _____ / _____
☐ No particular condition or symptoms -- Just seeking general good health

Describe the conditions, symptoms or purpose of the appointment: _____

_____

_____

Additional Information Related to the Condition:

Describe your pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache

What caused it? _____

What aggravates it? _____

What relieves it? _____

Have you ever had the same or similar condition or symptoms previous to this most recent occurrence? ☐ Yes ☐ No When? ___/___/___

Describe: _____

_____

Please indicate any other healthcare providers who you have seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	____/____/____
_____	_____	____/____/____

Please check any of the following symptoms you are now experiencing:

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea	☐ Head seems too heavy	☐ Neck Pain
☐ Loss of Memory	☐ Clumsiness	☐ Feet Cold	☐ Neck Stiff	☐ Tingling in arms/hands	☐ Ears Ring
☐ Hands Cold	☐ Sleeping Problems	☐ Tingling in legs/feet	☐ Face Flushed	☐ Nausea	☐ Back Pain
☐ Numbness in arms/hands	☐ Buzzing in Ears	☐ Constipation	☐ Nervousness	☐ Numbness in legs/feet	☐ Loss of Balance
☐ Cold Sweats	☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever	☐ Fatigue
☐ Irritability	☐ Loss of Smell	☐ Chest pain/rib pain	☐ Pain in arms/hands	☐ Pain in legs/feet	☐ Jaw pain
☐ Loss of strength - arms	☐ Burning muscle pain	☐ Loss of strength - legs	☐ Difficulty swallowing	☐ Sharp/shooting pain	

Other _____

Have you experienced changes to:
☐Eyes (sight) ☐Ears (hearing) ☐Nose (smell) ☐Mouth (taste) ☐Bladder ☐Bowels ☐Sleep ☐Emotion ☐Appetite
Please Explain: _____

Have you missed work or school due to your injuries? ☐ Yes ☐ No

Medical History:
Have you ever been in our office before? ☐ Yes ☐ No If no, how did you learn about our office? _____
List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) _____ ____/____/____
2) _____ ____/____/____
3) _____ ____/____/____

Who is your primary care physician? _____

Date of last physical examination? _____/_____/_____

Surgeries/Hospitalizations: _____

Allergies (please list all): _____

What medications or drugs are you taking? Please specify dosages.

_____

Do you now or have you ever had:

☐ Heart Trouble	☐ Diabetes	☐ Cancer	☐ Stroke	☐ High Blood Pressure	☐ Thyroid Problems
☐ Tuberculosis	☐ Prostate Disorder	☐ Kidney Problems	☐ Asthma	☐ Ulcer	☐ Seizure Disorder
☐ Dizziness	☐ Arthritis	☐ Digestive Disorders	☐ Backache	☐ Headaches	☐ Nervousness
☐ Numbness	☐ Sinus Trouble	☐ Hernia	☐ Neuritis	☐ Anemia	

Other: _____

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I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorneys who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information, which I have provided, is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: _____/_____/_____

Paciorek Health
(pa-CHOR-ek helth)

Dr. John Paciorek
Dr. Shanna Paciorek
Chiropractic Physicians