ALGRIM-FISHER CHIROPRACTIC OFFICE

PATIENT CONFIDENTIAL FORM

Thank you for choosing our office. Please print.

Date: _____

Last Name: _____ First Name: _____ Middle Initial: ____

Address: _____

City: _____ State: _____ Zip: _____

Contact phone: _____ Cell phone: _____

Email: _____

Occupation: _____ Employer: _____

Sex: **M / F** Birthdate: _____ Circle one: Married Single Widowed Divorced Partnered

Spouse's Name: _____ Employer: _____

Have you missed work because of this problem? **Y / N** Last date of work: _____

Is condition due to an accident? **Y / N** Date of accident? _____

Type of accident: Auto Work Other: _____

What is your main complaint? _____

How long have you had this problem? _____

What started this problem? _____

Rate your pain using the following scale. Circle the number that applies. **None apply**

1 2 3 4 5 6 7 8 9 10

Type of pain: Sharp Dull Throbbing Numbness Aching Swelling Burning Tingling Cramps Stiffness Shooting Other:_____

Is this condition getting worse? **Y / N** Remaining the same? **Y / N**

Activities or movements that are painful to perform: Sitting Standing Walking Bending

What treatment have you already received for your condition? _____

Please circle below to indicate if you have had any of the following:

Asthma	Alcoholism	Anemia	Arthritis
AIDS/HIV	Bleeding disorder	Breast lump	Bronchitis
Cancer	Cataracts	Chemical Dependency	Diabetes
Emphysema	Epilepsy	Glaucoma	Gout
Heart disease	Hepatitis	Hernia	Herniated disc
Hypertension	High Cholesterol	Kidney disease	Liver disease
Migraines	MS	Osteoporosis	Pacemaker
Parkinson's	Pinched Nerve	Polio	Prostate problems
Prosthesis	Rheumatoid arthritis	Stroke/TIA	Thyroid problems
Tuberculosis	Tumors	Ulcers	Other: _____

Are you a smoker? **Y / N** Alcohol: Drinks/Week _____ Coffee/Caffeine: _____
Exercise: None, Moderate, Daily, Heavy Stress Level: Low Medium High
Work Activity: Sitting Standing Light Labor Heavy Labor
Injuries/Surgeries you have had: _____

_____

_____

_____

Medications: _____

_____

Allergies: _____
Vitamins/Supplements: _____
Height: _____ Weight: _____ BP:_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Algrim-Fisher Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Algrim-Fisher Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. Furthermore, any risks involving treatment will be explained to me upon request. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Patient signature: _____ Date: _____

Parent/Guardian (if under 18) signature: _____ Date: _____

Algrim-Fisher Chiropractic Office

Dr. Daniel R. Algrim Dr. John L. Fisher