

# Welcome to Woodbury Chiropractic Center

## Patient Information

Thank you for choosing Woodbury Chiropractic Center for your acupuncture care needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

(please print clearly)

Date: \_\_\_\_\_

Name: (Mr. Mrs. Ms Dr.) \_\_\_\_\_ SS/HIC/Patient ID #: \_\_\_\_\_  
First Middle Initial Last

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing address if different: \_\_\_\_\_

Sex:  Female  Male Birthdate: \_\_\_\_\_ E-mail: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Do you prefer to receive calls at:  Home  Work  Cell  No Preference

Married  Widowed  Single  Minor  Separated  Divorced  Partnered # of Children \_\_\_\_\_

Patient Employer/School: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer/School Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Spouse or parent's name: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

My goal for consulting with the Acupuncturist: \_\_\_\_\_

## Symptoms

Reason for visit: \_\_\_\_\_

How serious do you think your problem is?  Annoying  Mild Limitations  Severe Limitations  Can't Function

Other complaints: \_\_\_\_\_

When did you first notice the symptoms? \_\_\_\_\_ Have you had similar conditions in the past? Y N

Please describe briefly what you hope to achieve from your treatments here: \_\_\_\_\_

What other treatments are you using to help these goals? \_\_\_\_\_

CURRENT MEDICATIONS (circle yes or no):

Coumadin: Y N Aspirin: Y N Antibiotics: Y N Antihistamines: Y N Pain Medications: Y N

What treatment have you received for your condition?

Now on medication  Surgery  Physical Therapy  Chiropractic  Other \_\_\_\_\_

Have you had acupuncture before? If so, for how long and for what purpose? \_\_\_\_\_

...continued on next page

**CONFIDENTIAL**

Circle the diseases below that have affected you or your family:

High Blood Pressure, Heart Disease, Cancer, Digestive Issues, Obesity, Migraines, Depression and/or Mental Illnesses, Respiratory Issues, Circulatory & Cardiovascular Issues, Bone and Muscle Issues, Pain Issues, Autoimmune Issues, Unusual Childhood Illnesses, and or other issues not mentioned above: \_\_\_\_\_

List any problem and/or concerns related to your health:

Respiratory: \_\_\_\_\_ Circulatory: \_\_\_\_\_

Digestive: \_\_\_\_\_ Urinary Tract: \_\_\_\_\_

Gynecological: \_\_\_\_\_ Bone/Muscle: \_\_\_\_\_

Pain: \_\_\_\_\_ Mental/Emotional: \_\_\_\_\_

Stress: \_\_\_\_\_ Autoimmune: \_\_\_\_\_

Allergies: \_\_\_\_\_ Infections (Acute or Chronic) \_\_\_\_\_

Any other issue not listed above \_\_\_\_\_

Recent MRI's, X-Rays, CT Scans or any other Diagnostic Testing? Date/where taken: \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition: \_\_\_\_\_

**Health History** Check only those conditions which are applicable:

- |   |  |  |   |   |
|---|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV           | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Mumps                | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Suicide Attempts   |
| <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herniated Disc      | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Depression          | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Tumors, Growths    |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Polio                | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Measles             | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Migraine Headaches  | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Miscarriage         | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Gout                | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Scarlet Fever        | _____                                       |

Dates of last exams: \_\_\_\_\_

(Woman) Are you pregnant?  Yes  No Nursing?  Yes  No Taking Birth Control Pills?  Yes  No

List any types of surgeries which you have had and the dates which they occurred: \_\_\_\_\_

Previous accidents/ Auto/Workers Comp/Personal: \_\_\_\_\_

Date/type of injury: \_\_\_\_\_

Please list all medications you are currently taking: \_\_\_\_\_

Allergies/Age of mattress: \_\_\_\_\_

**Daily Habits**

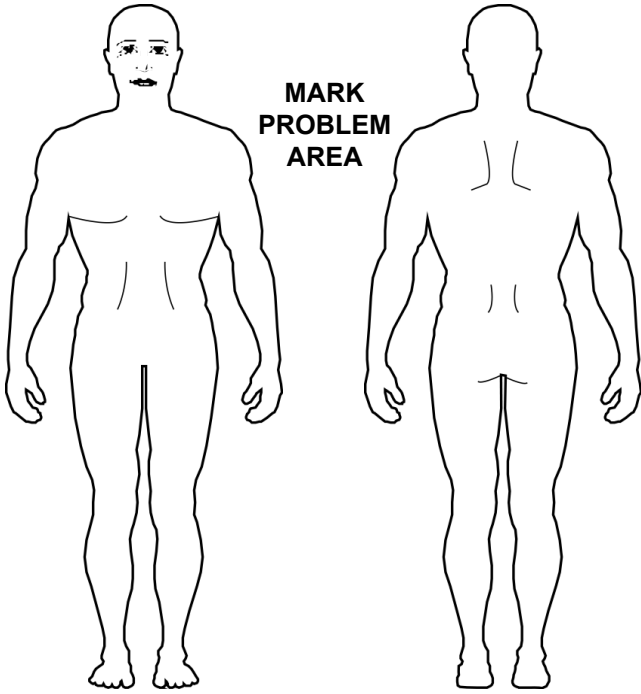
What type of exercise do you perform on a daily basis?  None  Moderate  Heavy

What do your daily work habits include? \_\_\_\_\_

What vitamins do you currently take? \_\_\_\_\_ Nutritional supplements (if any)? \_\_\_\_\_

Do you smoke?  Yes  No How much per day? \_\_\_\_\_

How much liquor do you consume weekly? \_\_\_\_\_ How many caffeinated beverages do you consume daily? \_\_\_\_\_



*Additional details can be provided below*

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***Insurance Information***

Name of insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Social Security#:: \_\_\_\_\_ Date employed: \_\_\_\_\_  
 Name of employer: \_\_\_\_\_ Work Phone: (\_\_\_\_)\_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Insurance Co.: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_  
 Group #: \_\_\_\_\_ Employer #: \_\_\_\_\_  
 Insurance Co. address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 How much is your deductible/copay? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit? \_\_\_\_\_

**Do you have additional insurance?**     Yes     No    **If Yes, please complete the following:**

Name of insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Social Security#:: \_\_\_\_\_ Date employed: \_\_\_\_\_  
 Name of employer: \_\_\_\_\_ Work Phone: (\_\_\_\_)\_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Insurance Co.: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_  
 Group #: \_\_\_\_\_ Employer #: \_\_\_\_\_  
 Insurance Co. address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

***Responsible Party***

Name of person responsible for this account: \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Name of employer: \_\_\_\_\_ Work Phone: (\_\_\_\_)\_\_\_\_\_

