PASSWORD_____

PATIENT INFORMATION

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please print)
Name_____ Date_____ S/S _____-_____-_____

Address_____ City_____ State _____ Zip _____

Sex: Female Male Height:_____ Weight:_____

Birth Date:_____ Home Phone# _____ Work Phone #:_____

Cell Phone#:_____ E-Mail Address _____

Do you prefer to receive calls at: Home Work Cell

Are you: Minor Married Divorced Widowed Single Separated

Do you have children? _____ How many:_____

Your employer:_____ Occupation_____

Business Address_____ City_____ State _____ Zip_____

Spouse's or parent's name_____ Workplace_____ Work Phone #_____

Whom may we thank for referring you to us?_____

Person to contact in case of emergency:_____ Phone #_____

RESPONSIBLE PARTY

Name of person responsible for this account:_____ DOB:_____

Relationship to patient_____ Phone #_____ SS#_____

Address_____ City_____ State _____ Zip _____

Name of employer_____ Work Phone #_____

SYMPTOMS

Reason for visit _____

When did you first notice symptoms?_____ Is this condition getting progressively worse?_____

Where specifically is the problem(s) located?_____

Which activities are difficult to perform? Sitting Standing Walking Bending Lying down

Which activities are you **unable** to perform? _____

How long have you been **unable** to perform these activities? _____

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

Rate the severity of your pain (1=mild pain or discomfort; to 10=severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go?_____

What treatment have you already received for your condition?

Medication Surgery Physical Therapy Chiropractic When? _____

How often? _____ Did it help?_____

Name of other doctor(s) who have treated you for your condition _____

HEALTH HISTORY

Circle only those conditions which are applicable

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

Date of last medical exam(s)_____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes or No

List **any** hospitalizations, surgeries and/or tests which you have had and the dates:

_____

Please list **all** medications you are currently taking:_____

Allergies:_____

Dates and description of auto accidents, personal injury/accidents:_____

_____

DAILY HABITS

How much exercise do you perform on a daily basis? None Moderate Heavy

What type of exercise do you do?_____

What do your daily work habits include (example: sitting, light labor, heavy labor, computer work)?

_____

What vitamins/ nutritional supports do you currently take?_____

Do you wear orthotics? _____

Do you smoke? No Yes How much per day?_____ Former Smoker?___

How much liquor do you consume on a weekly basis?_____

How much coffee or caffeinated beverages do you consume on a daily basis?_____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

SIGNATURE OF PATIENT (OR PARENT IF A MINOR)