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Confidential Patient Information

Please Print Clearly

Patient #_____ (Office Use Only)

Patient Data

Today's Date_____ First Name_____ Last Name_____

Name I would prefer to be called:_____ Sex: Male____ Female___ Age_____ Date of Birth____/____/_____

Who may we thank for your referral? _____ *Email Address_____

* Your email will NOT be shared with any 3rd parties, and is used for X-ray Repots and occasional office announcements.

Contact Information

Address_____ City _____ State _____ Zip_____

Cell Phone _____ Home Phone _____ Work Phone_____

Occupation_____ Employer_____ City of Employment_____

Status: Minor___ Single____ Have Significant other_____ Married ____ Divorced ____ Separated ____ Widowed____

Spouse's Name _____ Spouse's Occupation_____

Spouses Employer _____ Spouse's city of employment _____ Number of Children_____

Emergency Contact_____ Phone_____

Insurance Information

Name of party responsible for payment _____ Phone_____

Do you have insurance? ____No ____Yes Name of Company_____

Insurance Company Phone Number_____ Policy #_____

Signatures

Name of insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature _____ Date_____

If patient is under 18, Guardian Signature_____ Date_____

*** If an auto accident, please provide:** Insurance Company Name _____

Contact Person _____ Phone _____ Claim #_____

Nature of Injury

Nature of Injury: ___ Automobile* ____ Work ____ Other Date of Injury?_____

Reason for todays visit: ____ Injury ____ Chronic pain ____ Wellness Care ____Other

Please Explain: _____

Have you seen a Chiropractor Before? _____ Did he treat you for the above problem?_____ Last visit?_____

Current Complaints

What is your major complaints or concerns, please list your chief complaints in order of severity:

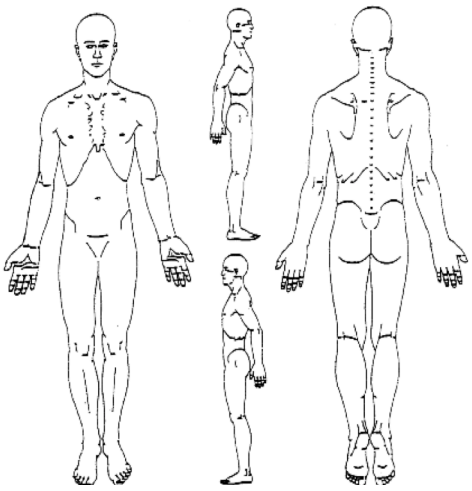
Symptoms	Duration	Circle One	Circle One
1. _____	For how long? _____	(Mild Moderate Severe)	(Constant On & Off Occasional)
2. _____	For how long? _____	(Mild Moderate Severe)	(Constant On & Off Occasional)
3. _____	For how long? _____	(Mild Moderate Severe)	(Constant On & Off Occasional)

1. Quality of Symptoms (what does it feel like?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing

2. Location of Problem

On the drawing below where does it hurt?



3. Radiation(To what areas does it travel or shoot)

_____

4. What makes if feel worse, such as time of day, movements, certain activities, etc.

_____

5. What tends to lessen the problem?

_____

6. What have you done to relieve the symptoms?

___ Prescription Drugs ____ Ice ___ Heat
___ Over the counter Drugs ___ Physical Therapy
___ Chiropractic ___ Massage ___ Acupuncture

Has it changed with time?	Getting worse	Not changing	Better
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

How do you think the problem began? _____

Who have you seen for this problem?

_____

Date of injury _____ Date symptoms appeared _____

What was the treatment or Diagnosis?_____

What was the results?_____

Activities or movements that are painful to perform:

Sitting _____ Standing _____ Walking _____ Bending _____ Lying Down _____

Does it interfere with work: **(Circle one for each question)**
Not at All, Slightly, Moderately, Substantially, Extremely

Does it interfere with social activities:
Not at All, Slightly, Moderately, Substantially, Extremely

Does it interfere with Family/Home Responsibilities:
Not at All, Slightly, Moderately, Substantially, Extremely

Does it interfere with self-care: (showering, driving, getting dressed etc.)
Not at All, Slightly, Moderately, Substantially, Extremely

How would you rated your overall health?_____

Dr. Use only

Medical History

Have you been treated for any conditions in the last year? _____No _____ Yes

If yes, please describe_____ Date of last Physical exam?_____

Have you had X-rays taken in the last year? _____No _____Yes If yes, where? _____

Any MRI, CT or Bone Scans? _____No _____Yes Please list any Birth Defects_____

Are you currently Diagnosed with a Diseases or Condition? Please explain_____

_____

What Medications are you taking and for what conditions: _____

_____

What vitamins, minerals or herbs do you currently take? _____

_____

Have you ever had:	**Please Check**	**No**	**Yes**	**Briefly Explain**
Broken bones?				
Been Hospitalized?				
Been in an Auto accident?				
Been struck unconscious?				
Had Surgery?				
Major injuries/falls but not hospitalized for?				

Your Health History

(please circle Yes or No on the questions below) **If yes please give brief explanation**

(Yes / No) AIDS/HIV _____
(Yes / No) Allergies _____
(Yes / No) Arthritis _____
(Yes / No) Acid Reflux _____
(Yes / No) Asthma _____
(Yes / No) Bladder(infections, frequent urination)_____
(Yes / No) Blurred Vision _____
(Yes / No) Buzzing/Ringing in the ear_____
(Yes / No) Back Pain/Tightness:
(Yes / No) Neck: _____
(Yes / No) Upper Back_____
(Yes / No) Mid Back _____
(Yes / No) Low Back _____
(Yes / No) Chest Pain _____
(Yes / No) Loss of Concentration _____
(Yes / No) Constipation_____
(Yes / No) Depression _____
(Yes / No) Digestions _____
(Yes / No) Dizziness/vertigo _____
(Yes / No) Fainting _____
(Yes / No) Heart (palpitations, Hyper tension etc.)_____

(Yes / No) Liver _____
(Yes / No) Lung _____
(Yes / No) Leg pain (R/L) _____
(Yes / No) Loss of energy _____
(Yes / No) Migraine Headaches _____
(Yes / No) Other Headaches _____
(Yes / No) Nervousness _____
(Yes / No) Numbness _____
(Yes / No) Hip _____
(Yes / No) Kidney _____
(Yes / No) Osteoporosis _____
(Yes / No) Prostate Issues _____
(Yes / No) Strokes _____
(Yes / No) Sleeping problems _____
(Yes / No) Sinus _____
(Yes / No) Shoulder Problems _____
(Yes / No) Thyroid issues _____
(Yes / No) Ulcers _____
Other _____
_____
_____