

WELCOME TO FAMILY CHIROPRACTIC OF BURR RIDGE

Name _____ Date _____ Social Security # _____
Address _____ Birth Date _____ Home Phone _____
City _____ State _____ Zip _____ Work Phone _____
Occupation _____ Marital Status: (Optional) S M W D
Referred By: _____ Employer _____

Please provide your e-mail address: _____ Height () Weight ()

If you have **Health Insurance** please present your card. Are your current problems due to an injury? Yes No

If yes: Auto accident, On the job injury, Personal injury. Was the accident reported? Yes No

List Complaints	1. _____	Date of onset	_____
	2. _____	Date of onset	_____
	3. _____	Date of onset	_____

Have you seen any other doctors for your chief complaint? Yes No Physician Name: _____

What was the diagnosis? _____

Do you suffer from any condition other than that for which you are consulting us? Yes No _____

List any previous broken bones, (fractures) or dislocations _____

List all previous surgeries _____ Pacemaker: Yes No

List all medications you are currently taking _____

Have you lost any weight recently without trying? Yes No Does pain keep you awake at night? Yes No

Do you have a fever? Yes No Smoking History: number of years _____ Packs smoked per day _____ Cough Yes No

Is there anything else about your health we should know about? _____

How did it happen? _____

Location of pain _____

Constant/Intermittent: _____ Position that relieves or aggravates: _____

Has this happened before _____

Worse / Better AM, PM _____

Radiation into extremity, (No) R L arm leg _____

Home care? Ice, Heat _____

Previous trauma _____ Does arthritis run in the family M F S B GF GM

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of chiropractic care, and I give authority for these procedures to be performed. All records and x-rays remain the property of this office, being on file where they may be seen at any time while a patient is at this office. The patient also agrees that he or she is responsible for all bills and any collection expenses incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient Signature _____ **Date** _____