Chiropractic Associates, Inc.
3305 NE Loop 286 Ste.A, Paris, TX 75460
903-785-5551

CONFIDENTIAL PATIENT INFORMATION:
DATE:_________

Patient Name:____________________________________
First Middle Last
Address:____

City:___________________ State:______ Zip:___________

E-Mail Address:___________________________________
(your email will be used for internal notifications only)

Sex: ( ) Male ( ) Female Number of Children________

Your Date of Birth:_____________ Your Age:___________
Month/Day/ Year
Please Check one:
( ) Married ( ) Single ( ) Divorced
( ) Separated ( ) Widowed ( ) Minor

Patient Employer:__________________________________

Occupation:_______________________________________

Employer Address:_________________________________

City:_________________ State:______ Zip:___________

Employer Phone Number:____________________________

Spouse's Name:____________________________________
First Middle Last
Spouse's Date of Birth:_____________ Age:__________

Spouse's Employer:_________________________________

Spouse's Employer Phone Number:____________________

PHONE NUMBERS:
Cell Phone:_______________________________________

Home Phone:______________________________________

Best Time To Reach You:____________________________

In Case of Emergency Call:

Name:____

Relationship:______________________________________

Contact Phone Number:_____________________________

INSURANCE INFORMATION:
Who is responsible for this account?__________________

Insurance Company:________________________________

Patient ID #:______________________________________

Group #:____
Is patient covered by any other Insurance? ( ) YES ( )NO

Subscriber's Name:_________________________________
(This is the person whose name the policy is under)

Relationship to Patient:___________ Date of Birth______
I Certify that I, and/or my dependent(s) have Insurance coverage with
Associates, Gregory Thompson, DC, Brandi Baggett, DC, and/or Sear
me for the services rendered. I understand that I am financially respon
authorize the use of my signature on all insurance submissions.

The above-named chiropractic doctors my use my healthcare informat
company(ies) and their agents for the purpose of obtaining payment fo
for services rendered. This consent will end one year from the date sig

PLEASE SIGN AND DATE:

X____
print name of patient, parent, guardian or responsible party

X____
signature of patient, parent, guardian or responsible party

Date:____________ Relationship to Patient:____________

Who may we send a thank you card for referring
you to our office___________________________________

Or how did you hear about our office?
( ) Google ( ) YellowBook ( ) Yahoo
( ) Bing ( ) Our Sign ( ) Radio/TV
( ) Word of Mouth ( ) Other:_________________________

PATIENT CONDITION:

1. What is the reason for your visit today? ____

2. Please list ALL symptoms you are having in order of severity:

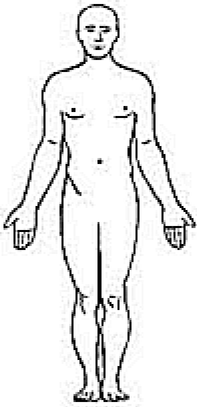
3. A.______________________ C._____________________ E.____________________

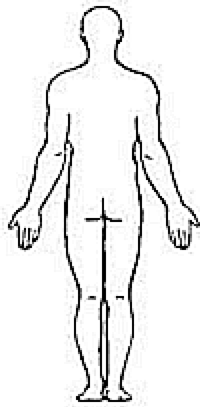
B.______________________ D._____________________ F._____________________

4. Circle the number that best describes your pain 0 1 2 3 4 5 6 7 8 9 10

None Mild Medium High Severe

5. Mark an X on the body diagram exactly where you are having symptoms, such as pain, numbness or tingling:





Do not write in box

Doctor Notes:

____

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____

____

6. When did your current symptoms first begin? ____

7. What might have caused your symptoms? ____

8. Is the condition getting worse since it first began? ( ) YES ( ) NO

9. How often do you have the pain? ( )Constantly ( )Frequently ( )Occasionally ( ) Intermittently

10. Are your symptoms changing with time? ( )Getting Worse ( )Staying the Same ( )Getting Better

11. Describe the Type of Pain: ( ) Sharp ( ) Dull ( ) Throbbing ( ) Numbness ( ) Aching ( ) Shooting ( ) Burning ( ) Tingling ( )Cramping ( ) Stiffness ( ) Swelling ( ) Sharp with Motion ( )Shooting with Motion ( ) Stabbing with Motion ( ) Electric like with Motion ( ) Other

12. Does the pain travel down your arms or legs? ____

13. Has your condition interfered with your and how much: a. ( ) Work ( ) Daily Routine ( )Recreation ( ) School
b. ( )Not at all ( )A little bit ( ) Moderately ( ) Quite a bit ( )Extremely

14. Activities that are now difficult: ( ) Sitting ( ) Standing ( ) Walking ( ) Bending ( ) Other:_________________

15. What. Aggravates your problem?____

16. What concerns you the most about your problem and what does it prevent you from doing?___________________________
____

17. What do you expect from undergoing chiropractic care? ____

18. Have you been to a Chiropractic doctor in the past? ____

HEALTH QUESTIONARE:

1. Height:________________________ Weight_________________ Date of Birth___________________________

2. How would you rate your overall Health? ( ) Excellent ( ) Very Good ( ) Good ( ) Fair ( ) Poor

3. What type of exercise do you do? ( ) Stenuous ( )Moderate ( ) Light ( ) None

4. What activities do you do at work? ( ) Sit ( ) Stand ( ) Computer Work ( )On the Phone How much of the day?___________________

5. Who is your primary medical doctor?____ Date of last exam?________________

6. Have you ever been hospitalized? ( ) No ( ) Yes If Yes, why____

7. Have you had significant past trauma? ( ) No ( ) Yes

8. Have you been evaluated by another doctor for your current condition? ( )Chiropractor ( )ER Physician ( )Massage Therapist ( )Neurologist ( )Orthopedist ( )Physical Therapist ( )Primary Care Physician ( )Other ( )No One

If YES, who and when? ____

9. Please check the past or present column if you have and/or had any of the following condition:

Past	Present		Past	Present		Past	Present	
		AIDS/ HIV			DIZZINESS			HEADACHE
		ALCHOLISM			FRACTURES			MULITPLE SCLEROISIS
		ANEMIA			SPINAL FRACTURES			OSTEOPOROSIS
		ARTHRITIS			GOUT			PACEMAKER
		ASTHMA			HEART DISEASE			DEFIBRILLATOR
		BLEEDING DISORDER			HEPATITIS A, B, or C			PARKINSON'S
		BREAST LUMP			HIGH CHOLESTERAL			RHEUMATOID
		CANCER			HIGH BLOOD PRESSURE			PINCHED NERVE
		DISC PROBLEMS			LIVER DIESEASE			PREGNANT
		CHICKEN POX			PROSTHESIS			PROSTATE PROBLEMS
		DIABETES			THYROID PROBLEMS			UNDER PSYCHIATRIC CARE
		STROKE			TUMORS / GROWTHS			ULCER
		TUBECULOSIS			HEART ATTACK			CHEST PAINS
		ANGINA			KIDNEY STONES			KIDNEY DISORDERS
		BLADDER INFECTION			PAINFUL URINATION			LOSS OF BLADDER CONTROL
		ABNORMAL WEIGHT GAIN /LOSS			LOSS OF APPETITE			ABDOMINAL PAIN
		GENERAL FATIGUE			MUSCULAR INCOORDINATION			VISUAL DISTURBANCES
		EXCESSIVE THIRST			FREQUENT URINATION			SMOKING/TOBACCO USE
		ALLERGIES			DEPRESSION			SYSTEMIC LUPUS
		EPILEPSY			BIRTH CONTROL			HORMONAL REPLACEMENT
		DERMATITIS/ECZEMA/RASH			UPPER BACK PAIN			MID BACK PAIN
		LOW BACK PAIN			SHOULDER PAIN			ELBOW/UPPER ARM PAIN
		WRIST PAIN			HAND PAIN			HIP PAIN
		UPPER LEG PAIN			KNEE PAIN			ANKLE/FOOT PAIN
		JAW PAIN			JOINT PAIN/STIFFNESS			CHRONIC SINUSITIS
		NECK PAIN			OTHER :			

Please list any other health conditions you may have:____

____

Indicate if you have any IMMEDIATE family members with the following: ( ) Rheumatoid Arthritis ( ) Diabetes ( ) Lupus ( ) Cancer ( ) Heart Problems ( ) ALS

HABITS

Do you smoke? YES / NO If yes, how many packs per day?__________________________________

Do you drink alcohol? YES / NO If yes, how may drinks per week?_________________________________

Do you use illegal drugs? YES / NO If yes, what type and how often?__________________________________

Please list your current medications:

1.____

2.____

3.____

4.____

5.____

6.____

7.____

8.____

Please list any medicatoions you are allergic to:____

Please list ALL surgeries you have had:

1.____

2.____

3.____

4.____

5.____

Do you have any metal implants related to previous surgery? YES / NO If yes, where?________________________________

Is there anything else pertinent to your visit today?____

Patient Signature:_________________________________ Date:______________________________