CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

Date ____________

Name (Full Legal) ____________ Social Security ____________ Home Phone ____________

Address ____________ City ____________ Zip Code ____________

Age ______ Birth Date ____________ Marital: M S W D How many children? ______

Occupation ____________ Employer ____________

Address ____________ Office Phone ____________

Guardian or Spouse's Name ____________ Social Security ____________

Birth Date ____________ Occupation ____________

Employer ____________ Address ____________

Patient's nearest relative or friend (not living at the same address) ____________ Phone ____________

Address ____________

Referred by (doctor, friend, or family member) ____________

Purpose of this Appointment (major complaint) ____________

____

Is condition due to injury or sickness arising out of patient's employment? ____________

Date symptoms appeared or accident happened: ____________ Have you lost any days from work? ____________

Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes and goes ☐

Is this condition interfering with your: Work ☐ Sleep ☐ Daily Routine ☐ Other ☐

Other Doctors seen for this condition: ____________

Patient ever had same or similar condition? ☐ Yes ☐ No If yes, when and describe ____________

____

Date of last physical examination: ____________ Female: Are you pregnant? ____________

What operations have you had? ____________

Serious illnesses? ____________ Fractured bones? ____________

Have you been treated for any health conditions by a physician in the last year? Yes ☐ No ☐

Describe ____________

What medications or drugs are you taking? ____________

Have you ever been under Chiropractic Care? Yes ☐ No ☐ Doctor's Name ____________

Have You Ever Suffered From:

- ☐ Allergy
- ☐ Dizziness
- ☐ Fatigue
- ☐ Headache
- ☐ Loss of sleep
- ☐ Ulcers
- ☐ Nervousness/Depression
- ☐ Numbness
- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Low back pain
- ☐ Neck pain or stiffness

Tingling or numbness in:

- ☐ Shoulders
- ☐ Arms
- ☐ Elbows
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet

- ☐ Poor Posture
- ☐ Sciatica
- ☐ Spinal curvatures
- ☐ Swollen joints
- ☐ Colon trouble
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Asthma
- ☐ Colds
- ☐ Deafness
- ☐ Ear noises
- ☐ Enlarged thyroid
- ☐ Eye Pain
- ☐ Failing vision
- ☐ Venereal Disease

- ☐ Tuberculosis
- ☐ Bruise easily
- ☐ Hay fever
- ☐ Nosebleeds
- ☐ Sinus infection
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Anemia
- ☐ Stroke
- ☐ Chest pain
- ☐ Difficult breathing
- ☐ Pleurisy
- ☐ Spitting
- ☐ Swelling of ankles
- ☐ Cancer

- ☐ Itching
- ☐ Varicose veins
- ☐ Bed-wetting
- ☐ Frequent urination
- ☐ Kidney infection or stone
- ☐ Prostate trouble
- ☐ Cramps or backache
- ☐ Excessive menstrual flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Lumps in breast
- ☐ Alcoholism
- ☐ Diabetes
- ☐ Polio
- ☐

Habits:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

DO YOU:

Now take Vitamins or minerals? ☐ Yes ☐ No

Think you may need vitamins or minerals? ☐ Yes ☐ No

Are you wearing: ☐ Heel lifts ☐ Sole lifts

☐ Inner soles ☐ Arch supports

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment ____________________

Payment: ☐ Cash ☐ Check ☐ Visa ☐ Master Charge ☐ Health Ins. ☐ Worker's Comp. ☐ Auto Med Pay

HEALTH INSURANCE

Insured's Name ____________________ Insured's Employer ____________________

Insurance Co. ____________________ Group or policy # ____________________

Address ____________________ Insured's SS# ____________________

JOB INJURY INFORMATION

Date ____________________ Time ____________________ Injury reported to Employer? ____________________

Description of Accident ____________________

Name of Workman's Comp. ____________________

Address of Insurance Co. ____________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature ____________________ Date ____________________

Guardian or Spouse's Signature Authorizing Care ____________________ Date ____________________

Information Taken By ____________________ Date ____________________

FAMILY HEALTH HISTORY

CONDITION	FATHER Age ( )	MOTHER Age ( )	SPOUSE Age ( )	BROTHER(s) Age ( ) Age ( )	SISTER(s) Age ( ) Age ( )	CHILDREN Age ( ) Age ( ) Age ( )
Arthritis						
Asthma - Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other						