CONFIDENTIAL PATIENT INFORMATION

DATE:_____ Patient #_____

Name:_____ Nickname:_____ Home Phone:_____
(First) (MI) (last)
SSN#_____ Cell Phone: _____ Work Phone:_____

Address:_____ City_____ State:____ Zip Code:_____

☐Male ☐Female Marital Status: ☐Married ☐Single ☐Widow ☐Divorced Date of Birth:____/____/____ Age:_____

Patient's Employer:_____ ☐ Full Time ☐Part Time ☐ Retired ☐Not Employed

Employer's Address:_____ Phone #:_____

Occupation:_____ How long have you been employed here:_____

Insured Name:_____ Insured Employer: _____

Address:_____ D.O.B_____ Are they responsible for Payment?☐Y ☐N

Student Status: ☐Full time ☐Part time ☐Non-student **How did you find out about our office?: _____**

CHIEF COMPLAINT:_____ **SECONDARY COMPLAINT**: _____

How long have you had this condition? _____ Date of onset_____

Are your symptoms (*circle one)* better than the same or worse than your date of onset?

What have you done in the past to help symptoms _____

Have you ever had a similar condition? ☐Y ☐N If yes, when? _____

Was the injury related to? ☐Auto accident ☐Previous Auto ☐Work accident ☐Previous work accident If yes, date _____

Recent/Previous Trauma? Explain: _____

What surgeries have you had? _____

Previous chiropractic care? ☐Y ☐N If yes, name of chiropractor: _____ Last visit: **___/___/____**

Reason for that initial visit?_____ Why are you changing chiropractors?_____

Name of Primary Care Physician?_____ List drugs you now take (prescription,

non-prescription, supplements) _____

RELEASE AND ASSIGNMENT

I authorize release of any information to process my insurance claims and assign and request payment directly to my physician.

Patient's Signature _____ Date:_____

Pregnancy Release:
This is to certify to the best of my knowledge I am not pregnant and the above doctor has my permission to perform an x-ray evaluation.
I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period? _____

Signature:_____Date:_____ (Please complete other side)

Patient History

What aggravates your condition? _____

Is your condition getting progressively worse? ☐Y ☐N ☐Constant ☐Comes and goes

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

Have you ever suffered from tingling, numbness or pain in: ☐Shoulders ☐Arms

☐Elbows ☐Hands ☐Hips ☐Legs ☐Knees ☐Feet ☐Fingers

Grandmother (GM), Grandfather (GF), Mother (M), Father (F), Sister (S), Brother (B), Child (C)

History of Illness:	You	Family	**History of Illness**:	You	Family
ADD/ADHD	☐	☐ ___	Epilepsy/seizers	☐	☐ ___
Arthritis	☐	☐ ___	Heart disease	☐	☐ ___
Autoimmune Problem	☐	☐ ___	Migraine headaches	☐	☐ ___
Bleeding Disorder	☐	☐ ___	Multiple Sclerosis	☐	☐ ___
Cancer	☐	☐ ___	Osteoporosis	☐	☐ ___
Depression	☐	☐ ___	Rheumatoid Arthritis	☐	☐ ___
Diabetes	☐	☐ ___	Stroke	☐	☐ ___

Please check if you have had any of these symptoms in the last 12 months:

☐ Other accidents, falls _____
☐ Eating disorders
☐ Trouble sleeping
☐ Trouble concentrating
☐ Learning disability
☐ Depressed*
☐ AIDS, HIV
☐ Kidney trouble
☐ Loss of bladder control/bedwetting*
☐ Hot Flashes
☐ Mood changes
☐ Menstrual problems, PMS
☐ Currently Pregnant*
☐ Digestive problems _____
☐ Ulcers*
☐ Chest pain, asthma
☐ High/Low blood pressure
☐ Varicose veins
☐ High Cholesterol*
☐ Allergy, sinus
☐ Frequent colds, flu
☐ Hearing Loss
☐ Ringing in ears R L
☐ Blurred or double vision
☐ Ear infections*
☐ Bruise easily
☐ Skin problems* _____
☐ Fractured Bones
☐ Under Stress
☐ Hernia
☐ Whiplash
☐ Neck pain or stiffness R L
☐ Headaches
☐ Dizziness
☐ Jaw pain or click (TMJ) R L
☐ Difficulty in excessive standing, sitting, riding, bending, lifting, twisting
☐ Shoulder pain R L
☐ Upper back pain, stiffness
☐ Mid back pain, stiffness
☐ Lower back pain, stiffness
☐ Sciatica R L
☐ Abnormal curvatures
☐ Hip pain R L
☐ Pain with cough, sneeze
☐ Foot trouble* R L
☐ Prostate problems
☐ Impotence*

Doctor's Notes: _____

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