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?: _____**

MAJOR COMPLAINT:_____ Secondary Complaint: _____

How long have you had this condition?_____ 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 Trauma? Explain: _____

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 other doctors seen for condition? _____ 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

History of Illness:	You	Family	History of Illness:	You	Family
ADD/ADHD	☐	☐	Epilepsy	☐	☐
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:

☐ Fractured Bones
☐ Hot Flashes
☐ Bruise easily
☐ Other accidents, falls
☐ Eating disorders
☐ Trouble sleeping
☐ Trouble concentrating
☐ Learning disability
☐ Mood changes
☐ Skin problems
☐ Allergy, sinus
☐ Frequent colds, flu
☐ Depressed
☐ Under stress
☐ Hernia
☐ Whiplash
☐ Hearing Loss
☐ Neck pain or stiffness R L
☐ Headaches
☐ Ringing in ears R L
☐ Dizziness
☐ Blurred or double vision
☐ 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
☐ Chest pain, asthma
☐ High/Low blood pressure
☐ Varicose veins
☐ Digestive problems
☐ Ulcers
☐ Prostate problems
☐ Impotence
☐ Kidney trouble
☐ Menstrual problems, PMS
☐ Currently Pregnant
☐ Bedwetting
☐ Ear infections
☐ AIDS, HIV
☐ High Cholesterol

Doctor's Notes: _____

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