# Patient Information

In order to provide you the best possible chiropractic care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

## Patient Data

**First** Name _____ Last Name_____ Referred By _____

## Mailing address

City _____ State _____ Zip _____

Telephone (work) _____ (home) _____ E-mail _____

Age _____ Birth date _____ Social Security # _____ Number of children _____

Occupation _____ Employer_____

Marital Status _____ Spouse's name _____ Spouse's Occupation _____

Spouse's employer _____ Spouse's health status _____

Emergency contact _____ Phone _____

## Current Complaints

Nature of injury: Automobile* ☐ Work ☐ Other ☐

Please describe _____

_____

Date of injury _____ Date symptoms appeared _____

Have you ever had same condition? ☐ No ☐ Yes If yes, when? _____

List other practioners seen for this injury/condition _____

Have you ever been under chiropractic care? ☐ No ☐ Yes

If yes, please describe _____

## Insurance Information

Name of party responsible for payment _____ Phone _____

Do you have health insurance? ☐ No ☐ Yes Name of company _____

** If an auto accident please provide:*

Insurance company name _____ Contact person _____

Phone _____ Claim # _____

## Billing Address

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

## Medical History

Have you been treated for any conditions in the last year? ☐ No ☐ Yes

If yes, please describe _____

Date of last physical exam _____ Is there a chance that you are pregnant? ☐ No ☐ Yes

Have you had X-rays taken? ☐ No ☐ Yes If yes, where? _____

What medications are you taking and for what conditions (Please list dosage and amounts, etc). _____

_____

_____

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency).

_____

_____

| Have you ever: | No | Yes | Briefly Explain |
|---|---|---|---|
| Broken bones? | ☐ | ☐ | _____ |
| Been hospitalized? | ☐ | ☐ | _____ |
| Been in an auto accident? | ☐ | ☐ | _____ |
| Had Sprains/Strains? | ☐ | ☐ | _____ |
| Been struck unconscious? | ☐ | ☐ | _____ |
| Had surgery? | ☐ | ☐ | _____ |

## Family History

| Family Member | Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.) |
|---|---|
| | |
| | |
| | |
| | |

| Habits: | None | Light | Moderate | Heavy |
|---|---|---|---|---|
| Alcohol | ☐ | ☐ | ☐ | ☐ |
| Coffee | ☐ | ☐ | ☐ | ☐ |
| Tobacco | ☐ | ☐ | ☐ | ☐ |
| Drugs | ☐ | ☐ | ☐ | ☐ |
| Exercise | ☐ | ☐ | ☐ | ☐ |
| Sleep | ☐ | ☐ | ☐ | ☐ |
| Appetite | ☐ | ☐ | ☐ | ☐ |
| Soft Drinks | ☐ | ☐ | ☐ | ☐ |
| Water | ☐ | ☐ | ☐ | ☐ |
| Salty Foods | ☐ | ☐ | ☐ | ☐ |
| Sugary Foods | ☐ | ☐ | ☐ | ☐ |
| Artificial Sweeteners | ☐ | ☐ | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Do you experience pain every day? | ☐ | ☐ |
| Do your symptoms interfere with daily life? | ☐ | ☐ |
| Does pain wake you up at night? | ☐ | ☐ |
| Are your symptoms worse during certain times of the day? | ☐ | ☐ |
| Do changes in weather affect your symptoms? | ☐ | ☐ |
| Do you wear orthotics? | ☐ | ☐ |
| Do you take vitamin supplements? | ☐ | ☐ |

What activities aggravate your symptoms?

_____

_____

_____

**Have you ever suffered from:**

- Alcoholism ☐
- Allergies ☐
- Anemia ☐
- Arteriosclerosis ☐
- Arthritis ☐
- Asthma ☐
- Back Pain ☐
- Breast lump ☐
- Bronchitis ☐
- Bruise Easily ☐
- Cancer ☐
- Chest Pain/Conditions ☐
- Cold extremities ☐
- Constipation ☐
- Cramps ☐
- Depression ☐
- Diabetes ☐
- Digestion Problems ☐
- Dizziness ☐
- Ears Ring ☐
- Excessive Menstruation ☐
- Eye Pain/Difficulties ☐
- Fatigue ☐
- Frequent Urination ☐
- Headache ☐
- Hemorrhoids ☐
- High Blood Pressure ☐
- Hot Flashes ☐
- Irregular Heart Beat ☐
- Irregular Cycle ☐
- Kidney Infection ☐
- Kidney Stones ☐
- Loss of memory ☐
- Loss of balance ☐
- Loss of smell ☐
- Loss of taste ☐
- Lumps In Breast ☐
- Neck Pain or Stiffness ☐
- Nervousness ☐
- Nosebleeds ☐
- Pacemaker ☐
- Polio ☐
- Poor Posture ☐
- Prostate Trouble ☐
- Sciatica ☐
- Shortness of breath ☐
- Sinus Infection ☐
- Sleep problems/insomnia ☐
- Spinal Curvatures ☐
- Stroke ☐
- Swelling of ankles ☐
- Swollen Joints ☐
- Thyroid Condition ☐
- Tuberculosis ☐
- Ulcers ☐
- Varicose Veins ☐
- Venereal Disease ☐
- Other: ☐

## Current Complaints (Continued)

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing