CONFIDENTIAL PATIENT INFORMATION

Name (first, middle, last) ________________________________ **Date** ______________
Home Phone ___________________ **Work Phone** ____________ **Cell** ______________
Which of the above numbers do you wish to be contacted at? __________________________
Address _________________________**City** ___________ **State** ____ **Zip** ___________
Email Address____________________________________

Birthdate ___________ **Age** ____ **Marital Status** M S W D **# of Children** ______
Soc. Sec. # ______________ **Employer** _______________ **Occupation** ______________
Work Address _______________________ **City** _________________ **Zip** ___________
Emergency Contact ________________ **Relationship** ____________ **Phone**___________

Name of Insured_____________________ **Birthdate**_____________ **SSN**___________

How did you hear about our clinic? ____
Have you ever had chiropractic care before? Y N Name of last chiropractor ______________

SYMPTOMS
Major area of complaint ____
Pain is (circle all that apply):

Dull/Achy Sharp Occasional Throbbing Constant

Intermittent Numbness and/or Tingling Worse with motion Varies in intensity

Have you ever had this problem before? [ ] Yes [ ] NO If so, when? _______________
When did the pain/problem start**?** _________________ [ ] Gradual [ ] Sudden
What do you think caused this problem? ____________________________
Is the problem getting: **better** **worse** **no change** over time?
Do your symptoms interfere with: ___ Work ___ Sleep ____Activities ___ Chores
How ____
What increases your pain? _________________ What decreases your pain? ______________
On a scale of 1-10 (10 being the most severe) please rate the severity of your symptoms:
1 2 3 4 5 6 7 8 9 10
List any other complaints currently bothering you and rate your pain level for each.
A ______________________________1 2 3 4 5 6 7 8 9 10
B ______________________________1 2 3 4 5 6 7 8 9 10
C ______________________________1 2 3 4 5 6 7 8 9 10
D ______________________________1 2 3 4 5 6 7 8 9 10

HEALTH HISTORY
Are you receiving care from other health professionals? [ ] Yes [ ] NO
If yes, please name them and their specialties _____________________________________
Have you ever been involved in a car or work-related accident? ______________________
Have you had any previous surgeries? Please list type and date:______________________
____

If you have experienced any of the following conditions in the past mark a **"P"** on the line provided. If you are currently experiencing any of the following conditions please mark a **"C"** on the line provided.

___Headaches ___Diarrhea ___Sinus problems ___Asthma
___Migraines ___Constipation ___Ulcers ___Dribbling of urine
___Neck pain ___Mid back pain ___Low back pain ___Frequent urination
___Sciatica ___Arthritis ___Dizziness ___Lo/High blood pressure
___Fatigue ___Diabetes ___Nausea ___Hemorrhoids
___Chest Pain ___Loss of balance ___Ears Ring ___Sudden weight loss
___Heart attack ___Gout ___Cancer ___Pins & Needles in arms
___Kidney stones ___Menstrual cramps ___Ankle sprains ___Pins & Needles in legs
___Indigestion/Acid Reflux ___Double vision/Floaters/Blurry vision
Other ____

Current medications (including over the counter):______________________________________
____

General activities (check all that apply)

___sleep on stomach ___read in bed ___fall asleep in recliner/on couch
___sleep on waterbed ___sewing ___needlepoint/knitting
___exercise _____x/wk ___smoke __packs/day ___drink alcohol _drinks/day
___drink coffee ___cups/day ___computer use __hours/day

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

____ _________________________
Signature (Parent's Signature if Patient is a Minor) Date

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

____ _________________________
Signature Date