

CONFIDENTIAL PATIENT INFORMATION

DATE: _____

Name: _____ (First) _____ (MI) _____ (last) Nickname: _____ Home Phone: _____
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: _____ Student Status: Full time Part time Non-student

If student, Parent's Names: _____ Phone #: _____

Parent's address: _____ Are they responsible for Payment? Y N

City: _____ State: _____ Zip code: _____

How did you find out about our office?: _____

MAJOR COMPLAINT: _____

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

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

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

Recent Trauma? Explain: _____

Previous Trauma? Explain: _____

What operations have you had? _____

Previous chiropractic care? Y N If yes, name of chiropractor _____

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

Name of other doctors seen for condition? _____ List drugs you now take (prescription and non-prescription) _____

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

History of Illness:	You	Family
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Fractured Bones | <input type="checkbox"/> Neck pain or stiffness R L | <input type="checkbox"/> Foot trouble R L |
| <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Chest pain, asthma |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Ringing in ears R L | <input type="checkbox"/> High/Low blood pressure |
| <input type="checkbox"/> Other accidents, falls | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Blurred or double vision | <input type="checkbox"/> Digestive problems _____ |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Jaw pain or click | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> (TMJ) R L | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Difficulty in excessive | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Mood changes | standing, sitting, riding, | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Skin problems | bending, lifting, twisting | <input type="checkbox"/> Menstrual problems, PMS |
| <input type="checkbox"/> Allergy, sinus | <input type="checkbox"/> Shoulder pain R L | <input type="checkbox"/> Pregnant (now) |
| <input type="checkbox"/> Frequent colds, flu | <input type="checkbox"/> Upper back pain, stiffness | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Mid back pain, stiffness | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Under stress | <input type="checkbox"/> Lower back pain, stiffness | <input type="checkbox"/> AIDS, HIV |
| | <input type="checkbox"/> Sciatica R L | <input type="checkbox"/> High Cholesterol |
| | <input type="checkbox"/> Abnormal curvatures | |
| | <input type="checkbox"/> Pain with cough, sneeze | |
| | <input type="checkbox"/> Hip pain R L | |
| | <input type="checkbox"/> Headaches | |

How would you rate your pain? Pain Intensity Scale: 0----1----2----3----4----5----6----7----8----9----10

Doctor's Notes: _____
