CONFIDENTIAL PATIENT INFORMATION

Today's Date: _____ Patient No.: _____

Name: _____ Date of Birth: _____ Age: _____SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Email Address: _____ Marital Status: M S How many children: _____

Occupation: _____ Employer: _____

Name of Insurance Company: _____

Subscriber: _____ Relationship to Subscriber: _____

Subscriber's Birth Date: _____ Subscriber's Employer: _____

Emergency Contact Person: _____ Home Phone: _____ Cell Phone: _____

Who can we thank for referring you to our office?: _____

Is your condition due to employment-related injury or sickness? Y N Is your condition due to an auto accident? Y N

Other injury where someone else may be liable? Y N If yes, explain circumstances: _____

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment: _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. By signing below, I am also giving authorization to release information to my insurance company or other liable entity as necessary to obtain reimbursement or coordinate care.

Patient Signature: _____Date: _____

Signature of Guardian or Spouse if authorizing care: _____ Date: _____

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Circle the choice that best indicates your level of problem: No symptoms Mild symptoms Extreme Symptoms

What is your chief complaint? _____Date symptoms appeared? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Y N Is it constant? Y N Does it come and go? Y N

Is this condition interfering with your work? Y N Have you lost any days from work? Y N If so, how many?_____

Is this condition interfering with your sleep? Y N Is this condition interfering with your daily routine? Y N

Have you ever been under Chiropractic Care? Y N Doctor's Name: _____

Primary Care Physician: _____ Date of last physical exam:_____

Other doctors seen for this condition? _____Have you ever had the same or similar condition? Y N

If yes, when and describe: _____

Have you been treated for any health conditions by a physician in the last year? Y N

If yes, please describe: _____

What medications or drugs are you taking? _____

What operations have you had? (include dates:) _____

Serious Illnesses? (include dates):_____

Fractured bones? _____ Females: Onset of LMP: _____ Are you pregnant? Y N

Have you ever suffered from:

____Allergy	____ Poor Posture	____Tuberculosis	____Itching	____Dizziness
____Bruise Easily	____Varicose Veins	____Fatigue	____Sciatica	____Spinal curvatures
____Hay Fever	____ Bed-Wetting	____Headache	____Swollen Joints	____Nosebleeds
____Loss of Sleep	____Colon Trouble	____Sinus infection	____Kidney Infection	____Kidney Stone
____Ulcers	____Diarrhea	____High blood pressure	____Prostate trouble	____Difficult digestion
____Nervousness	____Depression	____Low blood pressure	____Cramps	____Backache
____Numbness	____Hemorrhoids	____Pain over heart	____Arthritis	____Nausea
____Poor Circulation	____Hot flashes	____Bursitis	____Asthma	____Rapid Heart Beat
____Irregular Cycle	____Foot trouble	____Colds	____Slow heart beat	____Lumps in breast
____Low back pain	____Deafness	____Anemia	____Alcoholism	____Neck pains/stiffness
____Ear Noises	____Stroke	____Diabetes	____ Enlarged thyroid	____chest pain
____ Polio	____Eye Pain	____Difficult breathing	____Cancer	____Failing vision
____Pleurisy	____Swelling of ankles	____Venereal Disease	____Excessive menstrual flow	

Have you ever experienced tingling or numbness in:

____Shoulders	____Hips	____Toes	____Feet
____Legs	____Fingers	____Elbows	____Hands
____Arms	____Knees		

Do you:

Take vitamins or minerals? Y N

Think you need vitamins or minerals? Y N

Wear inner soles? Y N

Think you need inner soles? Y N

Habits:	Alcohol	Coffee	Tobacco	Drugs	Exercise	Sleep	Appetite
Heavy:	_____	_____	_____	_____	_____	_____	_____
Moderate:	_____	_____	_____	_____	_____	_____	_____
Light:	_____	_____	_____	_____	_____	_____	_____
None:	_____	_____	_____	_____	_____	_____	_____