PATIENT INFORMATION

Today's Date: _____

Thank you for choosing our office!

Please print. All information is confidential.

Name: _____
First MI Last

Home Telephone: _____Cell Number: _____

Cell Carrier (appointment reminders via text): ___AT&T ___Sprint ____Verizon ____T-Mobile Other: _____

Home Address: _____City: _____ State: _____Zip: _____

Birth Date: _____ SS#:_____ Marital Status ___S ____M ____D ____W

Number of Children: _____ Employer: _____ Occupation: _____

Work Phone Number: _____ How were you referred to the clinic? _____

Spouse: _____ Employer: _____ Work Phone: _____

Emergency Contact Person: _____Phone: _____

INSURANCE INFORMATION

(Only if other than the patient)

Name of Insured: _____Relationship to Patient: _____Birthdate: _____

SS#_____Insurance Company: _____

Polcy # _____ Group# _____

ILLNESS OR DISEASE

History of Chief Complaint: _____

_____

Other Doctor Consulted for This Condition:

Name: _____Address: _____City: _____ Zip: _____

Diagnosis/Treatment: _____

Current Medication and Dosage: _____

_____

PAST MEDICAL HISTORY

Accidents: __Personal ____Auto ____Work ____Other

Detail Diagnosis, Treatment, Disability, Etc.

_____

_____

_____

_____

Illness: _____

Hospitalizations, Blood Transfusions: _____

Have you ever had a bad fall, broken/fractured bones? _____

Family Disease History: _____

_____

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

Please complete back side of form ☞

HISTORY OF PRESENT PROBLEMS

What are your present complaints? _____

_____

_____

Date symptoms appeared or accident happened: _____

Have you lost any days from work? _____If so, how many? _____Returned to Work? Y N

Please check if you have had any problems with the following:

___Lifting 0lbs.-20lbs.
___Lifting 21 lbs. –50 lbs.
___Lifting 51 lbs.-100lbs.
___Reach/Working Above Shoulder
___Repeated Bending
___Operating a Motor Vehicle
___Walking
___Standing
___Sitting
—-Stooping
___Kneeling
___Climbing Stairs

Tingling or Numbness In:

___Shoulders ___Hips
___Arms ___Legs
___Elbows ___Knees
___Hands ___Feet

Please check if you have ever suffered from in the past, or are currently suffering from the following :
Check the box in the "P" column for past condition. Check the box in the "C" column for current condition.

P	C		P	C		P	C	
☐	☐	Allergy	☐	☐	Sciatica	☐	☐	Spinal Curvatures
☐	☐	Dizziness	☐	☐	Colon Trouble	☐	☐	Hay Fever
☐	☐	Fatigue	☐	☐	Diarrhea	☐	☐	Nosebleeds
☐	☐	Loss of Sleep	☐	☐	Hemorrhoids	☐	☐	Sinus Infection
☐	☐	Ulcers	☐	☐	Nausea	☐	☐	High Blood Pressure
☐	☐	Nervousness	☐	☐	Asthma	☐	☐	Low Blood Pressure
☐	☐	Depression	☐	☐	Colds	☐	☐	Pain Over Heart
☐	☐	Arthritis	☐	☐	Cancer	☐	☐	Poor Circulation
☐	☐	Bursitis	☐	☐	Varicose Veins	☐	☐	Rapid Heart Beat
☐	☐	Foot Trouble	☐	☐	Bed Wetting	☐	☐	Swelling of Ankles
☐	☐	Low Back Pain	☐	☐	Anemia	☐	☐	Hot Flashes
☐	☐	Mid Back Pain	☐	☐	Slow Heart Beat	☐	☐	Cramps or Backache
☐	☐	Upper Back Pain	☐	☐	Ear Noises	☐	☐	Excessive Menstrual Flow
☐	☐	Neck Pain or Stiffness	☐	☐	Diabetes	☐	☐	Irregular Cycle
☐	☐	Itching	☐	☐	Enlarged Thyroid	☐	☐	Lumps in Breast
☐	☐	Frequent Urination	☐	☐	Eye Pain	☐	☐	Kidney Infection or Stone
☐	☐	Prostrate Trouble	☐	☐	Failing Vision	☐	☐	Stroke
☐	☐	Deafness	☐	☐	Venereal Disease	☐	☐	Chest Pain
☐	☐	Alcoholism	☐	☐	Difficult Digestion	☐	☐	Difficult Breathing
☐	☐	Numbness	☐	☐	Polio	☐	☐	Pleurisy
☐	☐	Poor Posture	☐	☐	Tuberculosis	☐	☐	Spitting

_____ _____ _____ _____

Patient's Signature Date Doctor's Signature Date