CONFIDENTIAL PATIENT INFORMATION

Date:_____

Name:_____ Birth Date: M / D / Y

Address:_____ City, State:_____ Zip Code:_____

Cell Ph:_____ Daytime Ph:_____ Marital Status: S M D W Children #_____

Email:_____ Preferred Method of Contact: □ Cell □ Home □ Work □ Email

Occupation:_____ Employer:_____

Parent (if minor):_____ Closest Relative:_____ Relationship_____

How did you hear about our office?_____

Have you been to a Chiropractor before? □Yes □No Were X-rays Taken? □Yes □No If "Yes" when? M / D / Y

Chiropractor's Name:_____ City:_____

Medical Doctor's Name:_____ City:_____

What operations and/or serious illnesses have you had? _____

_____

What medications are you taking?_____

_____

What vitamin or mineral supplements are you taking?_____

Do you have any allergies to any medications? □Yes □No If Yes, what medication(s) _____

_____

Have you ever had or were told you had any of the following?

□Allergies	□Diabetes	□Heart condition	□Osteoporosis
□Aneurysm	□Digestive Disorder	□HIV	□Strokes
□Arthritis	□Dizziness	□Kidney Disease	□Ulcers
□Blood Disorder	□Epilepsy	□Liver Disease	□Tuberculosis
□Cancer	□Fainting Spells	□Lung disease	□Vitamin Deficiency

Do You Smoke? □Yes □No *Females*: Are you currently pregnant? □Yes □No or planning a pregnancy? □Yes □No

Purpose of this appointment (Major Complaint): _____

_____

Is this condition due to a motor vehicle accident? □Yes □No or a work related injury? □Yes □No

What is the date that your symptoms appeared or the accident happened: M / D / Y

Have you ever had the same or a similar condition? □Yes □No

Have you lost days from work? □Yes □No Is this problem getting progressively worse? □Yes □No

Is this problem interfering with your: □Performance at work? □Ability to sleep? □Daily routine? □Other_____

What aggravates your condition?_____

What makes it better?_____

How long has it been since you really felt good?_____

Please list any previous broken bones:_____

Have you seen another health care provider for this condition? □Yes □No If "yes", who?_____

Are you wearing: □Heel lifts □Arch supports □Custom orthotics □Other_____

What do you believe is wrong with you?_____

PAIN DIAGRAM

Draw in your face.
Show area(s) of pain or unusual feeling by marking the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness • • • • •
• • • • •

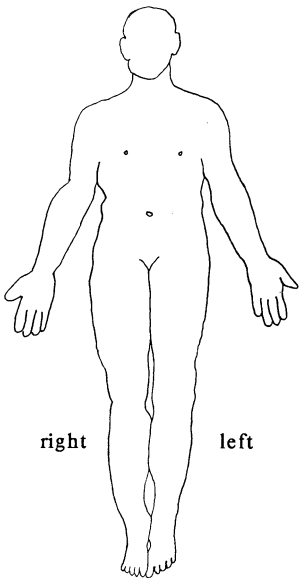
Pins & Needles 0 0 0 0 0
0 0 0 0 0

Burning X X X X
X X X X

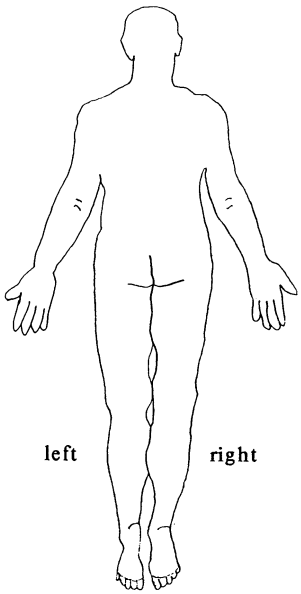
Aching * * * * *
* * * * *

Stabbing / / / / / / /
/ / / / / / /

Front



Back



VISUAL ANALOG SCALE

The lines to the right represent the intensity of your pain.
Please mark an "**X**" at the position on the scale, which indicates how much pain you feel

No Pain — Worst Pain Imaginable

at this time→ |———————————————|

at the worst→ |———————————————|

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment:_____ Are you insured? □Yes □No

Name of Insurance Company:_____Phone:_____

Insured's Date of Birth: Birth Date: M / D / Y Insured's Soc. Sec. #_____

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself, 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. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered 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 me will be immediately due and payable. It is also understood and agreed the amount paid this clinic for x-ray is for examination only and the x-ray negatives will remain the property of this office.

Patient's Signature:_____Date:_____

Guardian or Spouse's Signature Authorizing Care:_____Date:_____

DO NOT WRITE BELOW THIS LINE