ZUKER CHIROPRACTIC CONFIDENTIAL PATIENT INFORMATION Case # ____________ Date: ______________

Name: (Last)______________________________ (First) ____________________ (MI) _____
Address ______________________City ____________________ State _____ Zip ___________
Phone: (Home) __________________ (Work) ________________ (Cell) ________________
Preferred to be contacted at: home, work, cell, text, email ? Birth Date: ____/____/_______ Age _____ # of children _____
Sex: Male Female Marital Status: M S D W Separated email address ______________________
Occupation: ______________Business/ Employer: ______________________ # of years _____
Emergency contact: __________________ Relationship __________ Phone : ______________
Whom may we thank for referring you to us? ______________________(Yellow Pages, friend, Website, Dr., etc)
Chiropractors you have seen in the past: Name: ____________________ Date of last visit: ____________
My Primary insurance is: Blue Cross Blue Shield ____ Medicare ____ Medicaid ____ Other ______________
My Secondary insurance: Blue Cross Blue Shield ____ Medicare ____ Medicaid ____ Other ______________
Are your present problems due to: Auto accident ____ Work injury ____ Personal injury (fall, etc.) ____Date of Injury ________
Was injury reported? Y N Have you missed work or school due to this? Yes No Dates: ________________
Name of Primary Care Physician ______________________ May we contact them? Y N

SYMPTOMS:

Chief Complaint: ____
Did it begin Suddenly or Gradually? When? _________ What caused it? ______________________
Rate your Pain: (0 = Pain free, 10 = unbearable) 1 2 3 4 5 6 7 8 9 10 What % of the time do you notice it? ______%
What makes it worse?____________________ Things that make it better : ________________
Describe your symptom (pain, numb, sharp, dull, throbbing, etc?) ______________________
How long do symptoms last? (minutes,constant) ____________ Any treatments tried? ________________
Does it radiate? (arms, legs, head, etc) ______________ Are you numb anywhere? Y N Where? ___________
Any changes in bodily functions? (urination, bowel habits, sexual function, digestion, vision, other) Y N ___________
Have you had this same problem before? Y N When? ________ Any family history of this problem? ___________
Activities affected by this: __________________Any secondary complaints? __________________

General Health Information:

Height _____ Weight ______ Do you smoke? Y N Drink alcohol? Y N Play any sports? Y N Extreme Sports? Y N
On a scale of 1-10 describe your stress level: (1 = none and 10 = Extreme) Occupational ______ Personal ______
On a scale of **P**oor, **F**air, **G**ood, **E**xcellent, describe your:
Diet ___________ Exercise ___________ Sleep ___________ General Health _________
What Vitamins or other supplements (Omega oil, etc.) do you take? ______________________________
What medications or drugs are you taking, and why? ______________________________
____
Have you had **any** other health problems? ______________________________
Do you have a family history of problems with any of the following:
Diabetes Heart Kidney Cancer Back Stroke Arthritis Other ______________________

List any recent and/or past (w/ dates):

Accidents, falls or injuries: ______________________Hospitalizations: ______________________
Broken bones or dislocations: ______________Spinal treatments: ______________________
Tests performed i.e. X-Rays, ECG, MRI, CT, Bone Scan, Blood Tests, etc: ______________________
Surgeries /operations: ____

PAYMENT IS EXPECTED AT TIME OF VISIT !

Person responsible for payment: ______________________Soc. Security #______________
Are you insured? Yes ____ No ____ Company ______________________________
I will be paying today by: Cash _____ Check _____ Credit Card ____ Care Credit ____

***All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any necessary information pertaining to my treatment to third party payers or to other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that insurance payments may be less than the actual fee for services, and I agree that I am responsible for any outstanding amount owed to this office.**

Patient/ Guardian Signature______________________________________Date ______________