

CONFIDENTIAL PATIENT INFORMATION

PERSONAL HISTORY

Name _____ Address _____
City _____ State _____ Zip _____
Social Security # _____ Birth date _____ Age _____
Home Phone _____ Work Phone _____ Occupation _____
 Married Single Divorced Widow Email Address _____
Sex: Male Female Female patients: Are you pregnant? Yes No
Referred by: Phone Book Advertisement Friend/Family Name _____

PAST HEALTH HISTORY

Previous Chiropractic care?: Yes No Name of Dr. and date of last visit _____
Have you sought treatment for any health conditions in the last year? Yes No
If yes, please describe _____
Have you ever been injured in an auto accident? Yes No Date of Accident _____
Have you had residual problems due to a Sports injury Fall? Date _____
Date and description of surgeries: _____
What bones have you broken and when?: _____
Have you ever had: Heart Attack Stroke Cancer Ulcer

CURRENT HEALTH CONDITION

Reason for today's visit: #1 _____
#2 _____
Did your injury occur during: Work Auto Accident Sports Unknown Other
What aggravates your condition/pain? _____
What lessens your condition/pain? _____
Is condition getting worse? Yes No
Is condition interfering with Work Sleep Daily Routine Other _____
Other Doctors seen for this condition _____
Conditions for which you take prescription medication _____
Do you take vitamin supplements? Yes No Please list _____
Your current weight _____ height _____

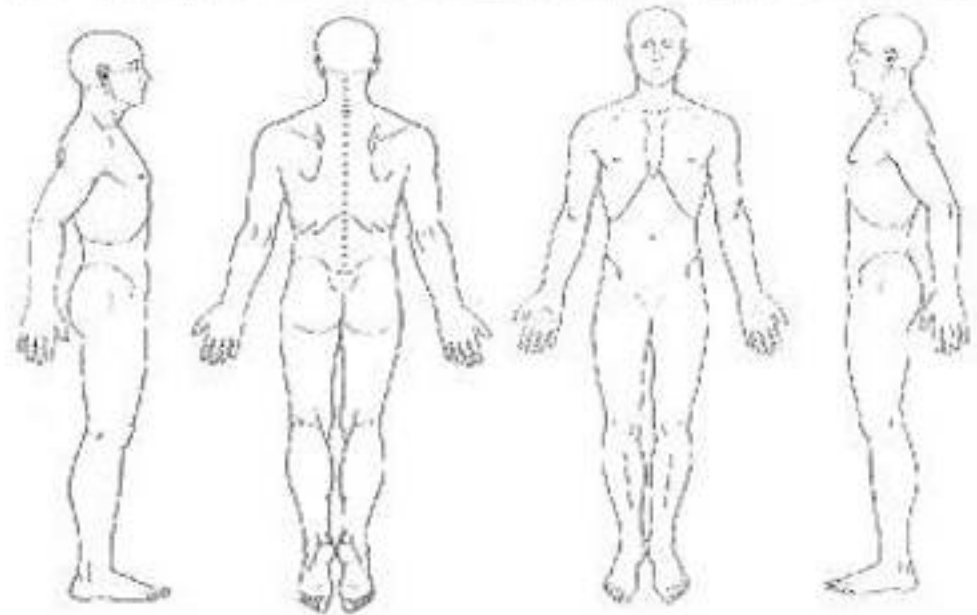
Mark symptoms you have experienced within the last 2 months:

- Dizziness Fatigue Headache
- Neck Pain Stiff Neck Back Pain
- Low Back Pain Sciatica
- Foot Trouble Prostate Trouble
- Enlarged Thyroid Rapid Heart Beat
- Pain Over Heart High Blood Pressure
- Swollen Joints Loss of Sleep
- Hay Fever Ulcers

Numbness/Tingling in:

- Arms Elbows Hands
- Hips Legs Feet

Place a mark on the body where you are having discomfort



HEADACHE

Rate your current pain level:
 No pain 1 2 3 4 5 6 7 8 9 10 worst pain
Rate the worst the pain has been:
 No pain 1 2 3 4 5 6 7 8 9 10 worst pain
Date this began _____
How frequent?
 Occasional/ intermittent/ frequent/constant
Does it radiate to another area? Yes / No
Where? _____

NECK PAIN

Rate your current pain level:
 No pain 1 2 3 4 5 6 7 8 9 10 worst pain
Rate the worst the pain has been:
 No pain 1 2 3 4 5 6 7 8 9 10 worst pain
Date this began _____
How frequent?
 Occasional/ intermittent/ frequent/constant
Does it radiate to another area? Yes / No
Where? _____

UPPER BACK PAIN/BETWEEN SHOULDER BLADES

Rate your current pain level:
 No pain 1 2 3 4 5 6 7 8 9 10 worst pain
Rate the worst the pain has been:
 No pain 1 2 3 4 5 6 7 8 9 10 worst pain
Date this began _____
How frequent?
 Occasional/ intermittent/ frequent/constant
Does it radiate to another area? Yes / No
Where? _____

MID BACK OR RIB PAIN

Rate your current pain level:
 No pain 1 2 3 4 5 6 7 8 9 10 worst pain
Rate the worst the pain has been:
 No pain 1 2 3 4 5 6 7 8 9 10 worst pain
Date this began _____
How frequent?
 Occasional/ intermittent/ frequent/constant
Does it radiate to another area? Yes / No
Where? _____

LOW BACK PAIN

Rate your current pain level:
 No pain 1 2 3 4 5 6 7 8 9 10 worst pain
Rate the worst the pain has been:
 No pain 1 2 3 4 5 6 7 8 9 10 worst pain
Date this began _____
How frequent?
 Occasional/ intermittent/ frequent/constant
Does it radiate to another area? Yes / No
Where? _____

OTHER

Please specify _____
Rate your current pain level:
 No pain 1 2 3 4 5 6 7 8 9 10 worst pain
Rate the worst the pain has been:
 No pain 1 2 3 4 5 6 7 8 9 10 worst pain
Date this began _____
How frequent?
 Occasional/ intermittent/ frequent/constant
Does it radiate to another area? Yes / No
Where? _____

Person responsible for payment _____ Insurance company _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand and authorize 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 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. 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.

PATIENT SIGNATURE _____ **DATE** _____
 Guardian's Signature authorizing care _____ **Date** _____