WELCOME TO FAMILY CHIROPRACTIC OF BURR RIDGE

Name _____ Date _____ Social Security # _____

Address _____ Birth Date _ _ _ _ _ _ _ _ Home Phone _____

City _____ State _____ Zip _____ Work Phone _____

Occupation _____ Marital Status: (Optional) *S M W D*

Referred By: _____ Employer _____

Please provide your e-mail address: _____ Height ( ) Weight ( )

If you have **Health Insurance** please present your card. Are your current problems due to an injury? *Yes No*

If yes: Auto accident, On the job injury, Personal injury. Was the accident reported? *Yes No*

List Complaints 1. _____ Date of onset _____

2. _____ Date of onset _____

3. _____ Date of onset _____

Have you seen any other doctors for your chief complaint? *Yes No* Physician Name: _____

What was the diagnosis? _____

Do you suffer from any condition other than that for which you are consulting us? *Yes No* _____

List any previous broken bones, (fractures) or dislocations _____

List all previous surgeries _____ Pacemaker: *Yes No*

List all medications you are currently taking _____

Have you lost any weight recently without trying? *Yes No* Does pain keep you awake at night? *Yes No*

Do you have a fever? *Yes No* Smoking History: number of years _____ Packs smoked per day _____ Cough *Yes No*

Is there anything else about your health we should know about? _____

How did it happen? _____

Location of pain _____

Constant/Intermittent: _____ Position that relieves or aggravates: _____

Has this happened before _____

Worse / Better AM, PM _____

Radiation into extremity, (No) R L arm leg _____

Home care? Ice, Heat _____

Previous trauma _____ Does arthritis run in the family *M F S B GF GM*

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of chiropractic care, and I give authority for these procedures to be performed. All records and x-rays remain the property of this office, being on file where they may be seen at any time while a patient is at this office. The patient also agrees that he or she is responsible for all bills and any collection expenses incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient Signature _____ **Date** _____