WELCOME

OPTIMUM HEALTH THROUGH CHIROPRACTIC CARE

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink.
If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name____Date___________Patient No.__________
First MI Last

Address_____________________________________City________________State_____Zip__________

Sex: ___Female ___Male S/S_______-______-_______ Birth date___________________

Home Phone #_________________________ Employer____

Employer Address_________________________________City_______________State_____Zip_______

Occupation__________________________ Name of Supervisor______________________________

Work Phone #______________ Cell Phone #____________ email ___________________________

Do you prefer to receive calls at: Home___ Work___ Either___

Are you: ____Minor ____Married ____Divorced ____Widowed ____Single ____Separated

Spouse's or Parent's Name__________________ Workplace ______________Work Phone #__________

Whom May We Thank For Referring You To Us?____

Person to Contact In Case of Emergency___________________________ Phone #___________________

Responsible Party

Name of Person Responsible for this account?____

Relationship to Patient_____________________________ Phone #________________________________

Address_________________________________ City___________________ State_____ Zip__________

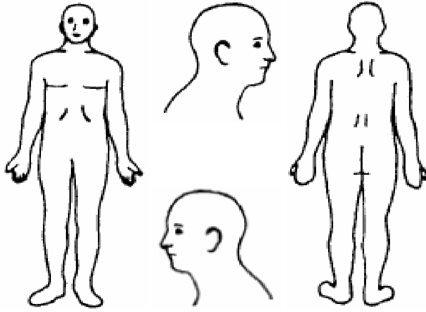
Insurance

Insured's Name ________________________________ Insured's Date of Birth______________________

Symptoms

Reason for Visit____ Is the condition getting progressively worse?___________________

When did you first notice the symptoms? ______________________ Where is the problem located?________________________________



PLEASE INDICATE PRECISELY THE AREA OF YOUR SYMPTOM
USING "XXX" ON THE FIGURE TO THE LEFT

Which activities are difficult to perform? ___Sitting ___Standing ___Walking

___Bending ___Lying Down ___Other

Type of Pain: ___Sharp ___Dull ___Throbbing ___Numbness ___Aching

___Shooting ___Burning ___Cramps ___Swelling ___Tingling ___Stiffness ___Other

Rate the severity of your pain. (1 Mild pain or discomfort, to 10, sever pain): 1 2 3 4 5 6 7 8 9 10

Is the Pain constant or does it come and go?____

What treatment have you already received for your condition? ____Medication ____Surgery ____Physical Therapy ____Other

Name & address of other doctor(s) who have treated you____

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Dates of last exams _____________________ List any surgeries & dates they occurred____

Please list all medications you are currently taking:____ Allergies:____________________

Daily Habits

What type of exercise do you perform on a daily basis? ___None ___Moderate ___Heavy

What do your daily work habits include? (Ex: Sitting, Standing, Light Labor, Heavy Labor, Computer) ____________________________

What Vitamins do you currently take?________________________________ Nutritional Supplements (if any) ______________________

Do you smoke? ____Yes____No How much per day?____________________

How much liquor do you consume on a weekly basis? _________________________

How much coffee or caffeinated beverages do you consume on a daily basis? ________________________

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents.

X____

Signature of Patient (or Parent if a minor) *Date*

Sinclair Chiropractic

GENERAL	NEUROLOGICAL	RESPIRATORY	GASTRO-INTESTINAL
___ sleeping disorder	___ blackouts / seizures	___ asthma / bronchitis	___ nausea
___ always tired	___ headaches	___ shortness of breath	___ vomiting / dry heaves
___ loss of appetite	___ dizziness / poor balance	___ breathing discomfort	___ heartburn / reflux
___ weight loss / gain	___ epilepsy	___ wheezing	___ bloating
___ restless legs	___ memory loss	___ emphysema	___ constipation/diarrhea—IBS
___ excessive thirst	___ tremors	___ sleep apnea	___ ulcers
___ recurrent infections	___ tingling, numbness or weakness in hands or feet	**CARDIO-VASCULAR**	___ black/ bloody stools
___ fever/ chills	___ stroke/ paralysis	___ chest pain	___ abdominal pain
___ night sweats/hot flashes	**EENT**	___ high blood pressure	___ hemorrhoids
___ drink alcohol	___ hay fever	___ rapid/ irregular heart beat	**GASTRO-URINARY**
___ smoke	___ sinus pain	___ ankle/ calf swelling	___ excessive urination
___ infectious disease	___ allergies	___ aneurysm	___ difficulty/ urgent urination
___ recreational drug use	___ visual disturbances	___ MVP	___ painful urination
___ last physical: ___________	___ glaucoma	**MUSCULOSKELETAL**	___ blood in urine
___ last blood work: _________	___ swallowing pain/difficulty	___ osteoporosis	___ waking to urinate at night
	___ hoarseness	___ swollen/ stiff joints	___ pelvic pain
SKIN	___ congestion	___ arthritis: _____________	___ STD
___ rash	___ hearing loss	___ gout	___ irregular menstruation
___ lesions/ moles	___ ringing in ears	___ scoliosis/ kyphosis	___ yeast infection
___ recurrent boils	___ ear pain	___ Fibromyalgia	**PSYCHIATRIC**
___ discoloring	___ ear drainage	___ joint reconstruction	___ fear
___ irregular growth/ pattern	___ vertigo/ motion sickness	___ joint replacement	___ anxiety
___ itching	___ headaches	**HEMATO-LYMPHATIC**	___ depression
___ breast pain	**CONDITIONS**	___ kidney/ liver disease	___ change in behavior
___ shingles	___ thyroid	___ swollen glands	___ loss of interest in hobbies
___ breast lumps (s)	___ cancer	___ anemia	___ hallucinations
	___ male problems	___ blood disorder	___ difficulty concentrating
	___ feminine problems	___ diabetes	
	___ blood clot	___ HIV/ aids	
		___ hepatitis A B C D	

Please explain any checked boxes above: ____

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