

PATIENT INFORMATION

Date _____
Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ SS# _____
Birth Date ___/___/___ Age _____ Sex _____
 Married Single Divorced Widowed
Whom may we thank for referring you? _____
What name do you prefer to be called? _____
May we add you to our email newsletter? Yes No
Email _____

EMPLOYMENT INFO

Occupation _____
Employer _____
Address _____
Phone # _____

EMERGENCY INFO

Contact Name _____
Relationship _____
Phone # _____

BILLING INFO

Who is responsible for your bill? You and:
 Spouse Health Insurance Workers' Comp. Auto Insurance
 Medicare
Primary Policy Holder's Name: _____
Date of Birth: _____ / _____ / _____

Previous chiropractic care: None Doctor's name & approximate date of last visit _____

CURRENT HEALTH CONDITION

Unwanted Health Condition: _____

When did the symptoms first appear? _____

[Mark your areas of concern on figure]

Has this condition occurred before? Yes No

How often do you experience the symptoms?

Constant 100% Frequent 75%
 Intermittent 50% Occasional 25% Rare 10%

What makes the symptoms worse? _____

What relieves the symptoms? _____

How would you describe the pain?

Sharp Dull Aching Burning Numb
 Throbbing Radiating Deep Other _____

Rate the pain on a scale of 1-10 (10 being unbearable pain):

Right Now 1---2---3---4---5---6---7---8---9---10

At Its Worst 1---2---3---4---5---6---7---8---9---10

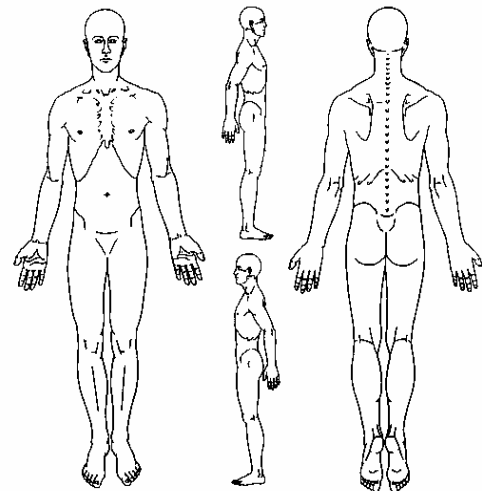
Other Doctors Seen For This Condition: Yes No Who? _____

Type of treatment? _____ Results? _____

Is this condition: Job Related Auto Accident Home Injury Fall Other: _____

Do you wear a shoe lift? Yes No

Do you suffer from any condition other than that which you are now consulting us?



Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD

- | | | | | |
|-----------------------------------|------------------------------------|-----------------------------------|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatic Fever |

CHECK ANY YOU HAVE HAD IN THE PAST 6 MONTHS

- | | | | |
|--|--|--|--|
| Musculoskeletal Code | General Code | C-V-R Code | Genitourinary Code |
| <input type="checkbox"/> General Stiffness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Bladder Trouble |
| <input type="checkbox"/> General Weakness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Short Breath | <input type="checkbox"/> Painful/Excessive Urine |
| <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Headache | <input type="checkbox"/> Asthma | <input type="checkbox"/> Discolored Urine |
| <input type="checkbox"/> Spinal Curvature | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Blood Pressure Problems | |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Irregular Heartbeat | For Women Only |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Fever | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Cramps |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Irregular Cycle |
| <input type="checkbox"/> Low Back Pain | Gastrointestinal Code | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Painful Periods |
| <input type="checkbox"/> Foot Trouble | <input type="checkbox"/> Poor/Excessive Appetite | <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Pregnant (now) |
| <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Vomiting | EENT Code | Family History |
| Nervous System Code | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vision Problems | The following members |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dental Problems | have a same or similar |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Constipation | <input type="checkbox"/> Sore Throat | problem as I do: |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Father |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Mother |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Abdominal Cramps | <input type="checkbox"/> Stuffed Nose | <input type="checkbox"/> Brother |
| <input type="checkbox"/> Cold/Tingling Extremities | <input type="checkbox"/> Gas/Bloating/Belching | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Sister |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Child |
| <input type="checkbox"/> Twitching | <input type="checkbox"/> Black/Bloody Stools | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Colitis | <input type="checkbox"/> Hoarseness | |

HEALTH HABITS

Exercise/Sports/Hobbies:

1) Type _____ Frequency _____ 2) Type _____ Frequency _____

3) Type _____ Frequency _____ 4) Type _____ Frequency _____

Sleep: Hours/night ____ Sleep quality _____ Do you sleep on your: Back Side Stomach

Smoking/Drinking/Diet: (how much and how often)

Tea/Coffee _____ Liquor/Beer _____ Cigarettes/Tobacco _____

OCCUPATIONAL INFORMATION

Job involves: Sitting Standing How long? _____

Bending Stooping Twisting Turning Lifting - How much weight? _____

Physical activity at work: Sedentary Light manual labor Heavy labor

Telephone use at work: None Moderate Heavy Traditional receiver Headset

Do any work activities aggravate your complaints? _____

Please list ALL surgeries, hospitalizations, fractures/dislocations you have had

Type _____ When _____

Type _____ When _____

Type _____ When _____

Please list ALL previous accidents and falls

What _____ When _____

What _____ When _____

What _____ When _____

Please list ALL medications and/or vitamins you take

Name _____ For What _____ Name _____ For What _____

Name _____ For What _____ Name _____ For What _____

Name _____ For What _____ Name _____ For What _____

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). The doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

Check here if you want the doctor to select the type of care appropriate for your condition.

METHOD OF PAYMENT

Cash Check Credit/Debit

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____

DO NOT WRITE BELOW THIS LINE

ANALYSIS: _____

DIAGNOSIS: _____, _____, _____, _____

Patient Accepted: Yes No Referred

Doctor's Signature _____