

Nuicare Integrative Health Center

CONFIDENTIAL PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____ Sex: M F

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

How many children? ____ Primary Doctor: _____ Social Security No.: _____

Occupation: _____ Employer Name? _____

City: _____ Office Phone: _____

Spouse's Name: _____ Referred By? _____

Email: _____

Insurance Information:

Subscriber's Name: _____ SSN# (if diff.) _____

Birth Date (if diff.) _____ Relationship to patient: Self Spouse Child Other: _____

Carrier Name: _____ Group# _____ Policy# _____

Emergency Contact: _____ Phone: _____ Relationship: _____

List Health Concerns according to major areas of complaint/symptoms	Rate severity 1-mild 10-worse	Date it started. What caused it?	Have you had this condition before, when?	% of time pain is present
1.				
2.				
3.				
4.				

Nucare Integrative Health Center

What makes your symptoms worse: Standing__ Sitting__ Laying down __ Walking__ Lifting__
Bending__ Other _____

Is this condition interfering with your: Work__ Daily routine__ Sleep__ Social activities__
Home life__ Sports/exercise__ Other_____

Are your symptoms worse during certain times of the day? Morning__ Afternoon__
Evening__ Night__ Other____

Has this problem been getting: Better__ Worse__ Same__

Do you wear orthotics? _____

Have you received any treatment for this condition? No one__ Chiropractor__ Physical therapist__
Medical__ Other_____

Have you consulted a Chiropractor in the past? Name: _____
Dates Consulted _____ For what Problem? _____

Have you ever been in an automobile accident?
Never _____ Past Year _____ Past 5 Years _____ Over 5 years _____

What surgeries have you had? When? _____

What medications are you currently taking and for what condition: _____

What vitamins, minerals, or herbs do you currently take? _____

Habits	None	Light	Moderate	Heavy
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				
Soft Drinks				
Water				
Salty Foods				
Sugary Foods				
Artificial Sweeteners				

Nuicare Integrative Health Center

Family History
Family Members- Present and past health conditions (Ex. Heart disease, cancer, arthritis...etc)

Have you ever suffered from: (please circle)

Alcoholism	Diabetes	Loss of smell
Allergies	Digestion problems	Loss of taste
Anemia	Dizziness	Muscle aches/Stiffness
Anxiety	Ears Ringing	Neck pain
Arteriosclerosis	Heavy menses	Numbness
Arthritis	Fatigue/Low Energy	Pacemaker
Asthma	Fibroids	Polio
Back pain	Fibromyalgia	Prostate Trouble
Bronchitis	Frequent urine	Scoliosis
Cancer	Hashimoto's	Sciatica
Chest pain	Headaches	Sinus infection
Cold extremities	High Blood Pres.	Sleep- going to
Constipation	Hot Flashes	Sleep- staying
Cramps	Irreg. heart beat	Stress
Cystic Breasts	Kidney stones	Stroke
Depression	Loss of memory	Swelling of ankles
	Loss of Balance	Thyroid condition
		Other _____

For women only:

Are You or Could You be Pregnant? _____

I understand and agree that Fees are payable at the time x-rays, examinations, and treatments are received. If you have insurance, we will be glad to process your claim but we request that you pay your estimated portion when services are rendered. Patients are ultimately responsible for their charges.

Patient's Signature _____ Date _____

Parent/Guardian Signature if Patient is a Minor _____ Date _____