PATIENT INFORMATION

PERSONAL INFORMATION

Today's Date: ______________________

Check the type of care desired: ❑ Temporary Relief ❑ Lasting Correction

Name: ____ **Social Security Number:** ______ -______-______

Date of Birth: ______ -______-______ **Age:** ________ **Height:** ________ **Weight:** ________

Check Marital Status: ❑ Married ❑ Single ❑ Other **Sex:** ❑ Male ❑ Female

Address: ____ **City:** ____________________

State: _______________ **Zip Code:** ______________________

Home Phone: ( )_________________ **Work Phone:** ( )_________________ **Cell:** ( )________________

Email Address: ____

Nearest Relative: ____ **Phone:** ( )____________________

Address: ____ **City:** ____________________

State: _______________ **Zip Code:** ______________________

Are you pregnant? ❑ No ❑ Yes Date of Last Menstrual Cycle: _____________

EMPLOYMENT INFORMATION

Occupation: ____________________________________ **Employer:** ______________________

Employer Address: ____ **City:** ____________________

State: ___________________ **Zip Code:** ___________________ **Phone:** ( )____________________

Spouse's Name: ____________________________________ **Employer:** ______________________

Employer Address: ____ **City:** ____________________

State: ___________________ **Zip Code:** ___________________ **Phone:** ( )____________________

PAYMENT INFORMATION

How will payment be made? *(please check one of the following)*

❑ Cash ❑ Check ❑ Credit Card ❑ Auto Insurance ❑ Health Insurance ❑ Worker Comp

Insurance Company ___________________________________ **Policy #** _____________________ **Group #** ___________________

Name Of Primary: ____ **Social Security Number:** ______ -______-______

Fees are payable at the time X-rays, examinations/treatments are received unless other arrangements are made in advance. X-rays remain the property of the clinic. All accounts over (30) days delinquent will be subject to a 1.5% monthly periodic interest charge to the unpaid balance. All accounts over (60) days delinquent will be turned over for collection or judgment in small claims court. All collection fees, filing fees, attorney fees and court costs incurred by this office in collecting accounts will be charged to the patient.

**By signing below I acknowledge that I have read and understand the HIPPA regulations regarding the privacy of my records and that I reserve the right to designate release of information to any third party.*

Patient Signature: ____

Guardian/Parent Signature Authorizing Care: ____

PATIENT HISTORY FORM

Patient Name: ____________________

What is your primary reason for seeking care today? ____________________

Have you missed any work due to this condition? ❑ No ❑ Yes

What dates? ____________________

What treatment have you received for this condition?

❑ Physical Therapy ❑ Surgery ❑ Medication ❑ None

❑ Chiropractic Services ❑ Other ____________________

Name and address of previous doctor(s) who have treated your condition:

Date of Last: Physical Exam ________ Spinal X-Ray ________ Blood Test ________ Urine Test ________

What expensive diagnostic test have you had?

❑ MRI ❑ CT ❑ EMG

❑ Other ____________________

List all prescription and non-prescription drugs you are currently using: ____________________

____

List any surgeries you have had: ____________________

____

Please list any past broken or fractured bones: ____________________

Have you ever suffered from:

❑ Dizziness	❑ Tuberculosis	❑ Digestive Disorders	❑ Asthma	❑ Arthritis
❑ High Blood Pressure	❑ Sinus Trouble	❑ Headache	❑ Nervousness	❑ Diabetes
❑ Numbness	❑ Anemia	❑ Migraine Headaches	❑ Heart Disease	❑ Stroke
❑ Arteriolosclerosis	❑ Osteoporosis	❑ Bleeding Disorders	❑ Cancer	

Other ____________________

____

Do you exercise? ❑ No ❑ Yes

What type(s) and frequency of exercise? ____________________

____

____

What activities does your job entail?

❑ Prolonged Sitting ❑ Lifting ❑ Computer Use ❑ Twisting

❑ Prolonged Standing ❑ Stooping ❑ Repetitive Motions

How would you rate your diet? (1 being poor and 10 excellent) **1——————5——————10**

Do you take vitamins? ❑ No ❑ Yes

What type(s)? ____________________

Would you say your sleep is: ❑ Good ❑ Fair ❑ Bad

Your sleeping position is: ❑ Back ❑ Side ❑ Stomach

Do you smoke? ❑ No ❑ Yes How much? ____________________

How would you rate your stress levels? **Home: 1——————5——————10**

Work: 1——————5——————10

Overall how do you feel today? (1 being terrible and 10 being healthy) **1——————5——————10**

COMPLAINT(S): List in order of severity

1) ___

Date when symptons first appeared: ___

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

Describe any related accidents or falls ___

___

___

What makes symptoms increase? ___

What gives relief? ___

Type of Pain:

- ❑ Sharp ❑ Dull ❑ Aching ❑ Burning
- ❑ Throbbing ❑ Numb ❑ Other ___

Does the pain radiate? ❑ No ❑ Yes

Where to? ___

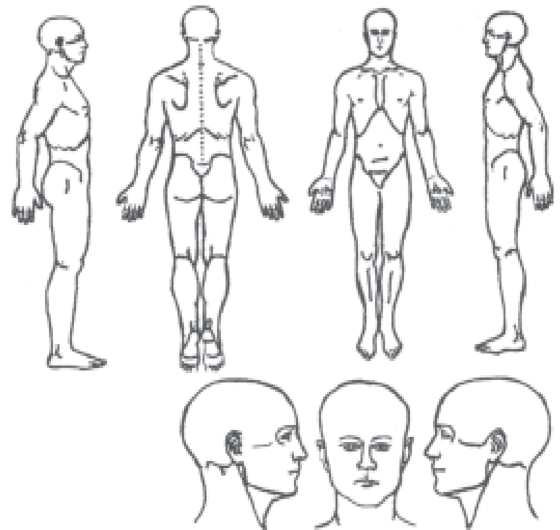
How bad is the pain? (1 no pain - 10 unbearable)

1————5————10

Doctors seen: ___

Does this interfere with: ❑ Work ❑ Sleep ❑ Activities

****Please mark areas of pain on figures below**



What medication(s) have you taken for this condition?

___

___

___

___

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2) ___

Date when symptons first appeared: ___

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

Describe any related accidents or falls ___

___

___

What makes symptoms increase? ___

What gives relief? ___

Type of Pain:

- ❑ Sharp ❑ Dull ❑ Aching ❑ Burning
- ❑ Throbbing ❑ Numb ❑ Other ___

Does the pain radiate? ❑ No ❑ Yes

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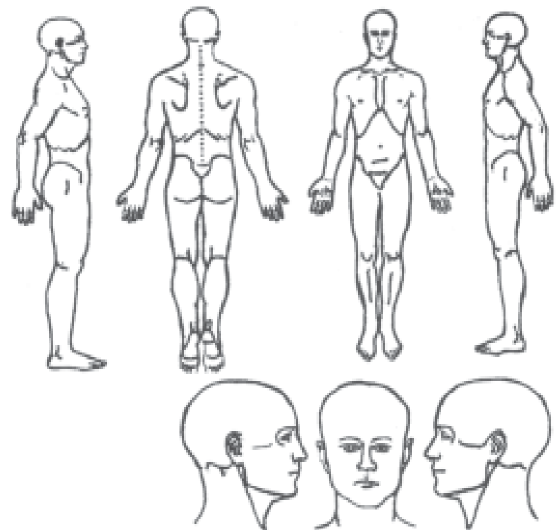
1————5————10

Doctors seen: ___

Does this interfere with: ❑ Work ❑ Sleep ❑ Activities



What medication(s) have you taken for this condition?

___

___

___

___

Date: ______________________

PATIENT NAME: ____

Please review the below listed diseases and conditions and indicate those that are current health problems of a family member by the designation **‘C’** under his or her column. The designation **‘P’** should be used ot indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTER(S)		CHILDREN		
	Age _____	Age ____	Age _____	Age _____	Age _____	Age _____	Age _____	Age _____	Age _____	Age _____
Arthritis										
Asthma										
Back Trouble										
Bursitis										
Cancer										
Carpal Tunnel										
Constipation										
Diabetes										
Disc Problems										
Emphysema										
Epilepsy										
Fibromyalgia										
Headaches										
Heart Trouble										
High BP										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Nervousness										
Neuritis										
Pinched Nerves										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										
Other:										