Confidential Patient Information

Welcome

We want to get to know you and appreciate you filling in our forms!

Please Print

Name _____ Address _____

City _____ State _____ Zip Code _____

Home phone: _____ Cell Phone: _____

Social Security #: _____ Date of Birth: _____

Age: _____ Sex: ☐ M ☐ F Marital Status: ☐ M ☐ S ☐ D ☐ W

Email address: _____ Who may we thank for your referral? _____

Employer

Occupation: _____ Employer: _____

Employer Address _____ City _____ State _____ Zip Code _____ Employer Phone _____

Spouse

Spouse's Name _____ Spouse's Employer _____ Occupation _____

Children and Ages

_____

_____

Emergency Contact

Name _____ Address _____

City _____ State _____ Zip Code _____

Contact phone: _____ Cell Phone: _____

Insurance Information

If you have an insurance card, we will be happy to copy it.

Primary Insured: _____ Policy Holder's Date of Birth: _____ Policy Number: _____

Insurance Company _____ Address _____

City _____ State _____ Zip Code _____

Insurance Patients I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I authorize the release of any medical information necessary to process this claim and authorize payment of services to this office. I understand any amount paid directly to the office will be credited to my account. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. Please make payment for your portion of charges at each visit unless other arrangements are made.

Patient's Signature _____ Date _____

Patients Without Insurance Please pay for services at the time of each visit. We accept Visa, MasterCard, checks or cash. If you prefer, a payment plan will be set up for your convenience. Let us know which one you prefer (check one.)

☐ Payment at time of service ☐ Payment Plan

Patient's Signature _____ Date _____

Symptoms

1. What is your number-one problem or the one area of greatest pain? _____

2. Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain. 0 1 2 3 4 5 6 7 8 9 10

3. When did this problem/pain start? _____ ☐ Gradual ☐ Sudden ☐ Progressive

4. What do you think caused this problem? _____

5. How often do you experience the pain?

☐ 1-2 hours per day ☐ About half of the day

☐ Most of the day ☐ The pain never goes away

6. How does the pain affect your daily activities?

☐ It does not affect my daily activities ☐ I have had to change how I do things

☐ I have had to stop doing some of my daily activities ☐ I am unable to perform daily activities

7. What increases your pain? _____

8. What decreases your pain? _____

9. Have you ever experienced this problem before? ☐ **Y** ☐ **N** When? _____

10. List any other complaints currently bothering you and rate your pain level for each using the same scale as above.

a. _____ 0 1 2 3 4 5 6 7 8 9 10

b. _____ 0 1 2 3 4 5 6 7 8 9 10

c. _____ 0 1 2 3 4 5 6 7 8 9 10

d. _____ 0 1 2 3 4 5 6 7 8 9 10

11. Have you ever been involved in an automobile accident? ☐ **Y** ☐ **N**

a. If yes, when? _____

b. Were you injured? ☐ **Y** ☐ **N** Please explain: _____

12. Have you ever been injured at work? ☐ **Y** ☐ **N**

a. If yes, when? _____

b. Please explain: _____

13. List all medication you are currently taking *(prescribed and over the counter)* _____

14. List all surgeries you have had *(with date)* _____

If you have experienced any of the following conditions in the past mark a "P" on the line provided. If you are currently experiencing any of the following conditions please mark a "C" on the line provided. (mark all that apply)

☐ heart attack	☐ stroke	☐ arthritis	☐ gall bladder trouble
☐ diabetes	☐ glaucoma	☐ fainting spells	☐ kidney stones
☐ difficulty with urination		☐ bloody stools	☐ difficulty with bowel movements
☐ prostate trouble	☐ anemia	☐ cancer	☐ asthma
☐ AIDS	☐ ulcers	☐ diverticulosis	☐ menstrual cramping
☐ dizziness	☐ loss of memory	☐ chest pain	☐ shortness of breath
☐ constipation	☐ diarrhea	☐ general fatigue	☐ sudden weight loss
☐ nausea	☐ muscle cramping	☐ soreness in joints	☐ loss of hearing
☐ ears ringing	☐ headache	☐ migraine	☐ epilepsy
☐ gout	☐ tuberculosis	☐ syphilis	☐ sprained ankle ☐ R ☐ L
☐ knee/hip replacement		☐ broken bones (specify)	

General Activities (check all that apply)

☐ sleep on waterbed	☐ read in bed	☐ fall asleep in recliner/on couch	☐ sleep on stomach	☐ needlepoint/knitting
☐ use two or more pillows to sleep with		☐ sewing	☐ lift weights/wt. mach.	
☐ play video games (____ hrs per day)		☐ exercise____ x/wk	☐ jog____ x/wk	
☐ computer use (____ hrs per day)		☐ swim	☐ use treadmill	☐ watch television (____ hrs per day)

Females; are you pregnant? ☐ Y ☐ N Date of your Last Menstrual Cycle: _____

Have you ever received chiropractic care in the past? ☐ Y ☐ N Last Date Treated: _____

Please add anything else you would like the doctor to know:

_____

_____

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office 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 this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____ Date _____

(signature of parent if the patient is a minor)

Doctor's Comments: _____

_____

_____

_____

_____