Patient Information

Name: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip:_____ SSN: _____

Date of Birth :_____ Age: _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Cell phone:_____

Email address: _____

Employer: _____ Work Phone:_____

Please describe your occupation: _____

Spouse Name: _____ Date of Birth: _____

Emergency Contact: _____ Phone: _____

Who referred you to our office? _____

Have you had chiropractic care before? ☐ Yes ☐ No If yes, where?_____

Insurance Information

1.) Primary Insurance Company: _____

ID or Contract #: _____ Group#:_____

Subscriber's Name: _____ Date of Birth: _____

Subscriber's Address: _____

City: _____ State: _____ Zip: _____ Phone:_____

2.) Secondary Insurance Company: _____

ID or Contract #: _____ Group #: _____

Subscriber's Name: _____ _____ Date of Birth:_____

Subscriber's Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

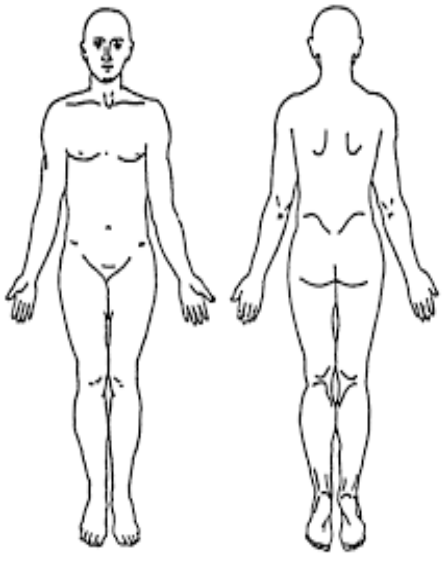
Reason for Visit

Are you coming to see us as a result of:

☐ An auto accident ☐ A work-related injury ☐ A personal injury

Other doctors seen for this condition: _____

Circle the areas to the right where you have pain or other symptoms →



Please describe your symptoms:_____

_____

_____

When did your symptoms start? _____

Have you had similar conditions in the past? _____

PLEASE COMPLETE BOTH SIDES

Is your primary complaint worse in the: ☐ a.m. ☐ p.m. ☐ same

Rate the intensity of your pain: (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

Is your pain worse when: ☐ Sitting ☐ Standing ☐ Lying down

What helps relieve your discomfort? ☐ Ice ☐ Heat ☐ Rest ☐ Movement ☐ Nothing

Please check any of the following that give you difficulty:

☐ Headache	☐ Loss of balance	☐ High blood pressure	☐ Menstrual cramps & pain
☐ Shooting head pains	☐ Ringing in ears	☐ Low blood pressure	☐ Menstrual irregularity
☐ Sinus trouble	☐ Blurred vision	☐ Anemia	☐ Bladder irregularity
☐ Loss of smell	☐ Lights bother eyes	☐ Stomach trouble	☐ Bowel irregularity
☐ Allergies	☐ Neck pain	☐ Nerves/nervousness	☐ Diabetes
☐ Hayfever	☐ Muscle spasms in neck	☐ Inner tension	☐ Cancer
☐ Asthma	☐ Grinding in neck	☐ Irritability	☐ Sleeping problems
☐ Loss of taste	☐ Tightness of shoulders/arms	☐ Gallbladder trouble	☐ Painful joints
☐ Thyroid trouble	☐ Pain in shoulders/arms	☐ Indigestion	☐ Swollen joints
☐ Twitching of face	☐ Pins /needles in arms/hands	☐ Intestinal gas	☐ Pins & needles in legs
☐ Loss of memory	☐ Cold hands	☐ Low back pain	☐ Swollen ankles
☐ Fatigue	☐ Numbness in arms/hands	☐ Ulcers	☐ Cold feet
☐ Depression	☐ Shortness of breath	☐ Numbness in legs/feet	☐ Pains in legs/feet
☐ Dizziness	☐ Mid back pain	☐ Constipation	☐ Other_____
☐ Fainting	☐ Heart attacks	☐ Kidney trouble	☐ Other_____

Have you ever had any falls, auto accidents, or injuries? ☐ Yes ☐ No If yes, please explain:

Month/Year:_____ Type of Accident:_____

Describe Injury: _____

Month/Year:_____ Type of Accident:_____

Describe Injury: _____

Have you ever had surgery? ☐ Yes ☐ No If yes, please explain:

Month/Year: _____ Type of surgery: _____

Month/Year: _____ Type of surgery: _____

Are you presently taking medication or vitamins? ☐ Yes ☐ No If yes, please list:

Name of drug: _____ Name of drug: _____

Name of drug: _____ Name of drug: _____

Do you smoke? ☐ Yes ☐ No **Drink alcohol?** ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently

What exercise programs do you currently participate in? _____

Family History

Do any of your blood relatives have any of the following (list relation to you):

☐ Diabetes	Relation: _____	☐ Cancer	Relation: _____
☐ Stroke	Relation: _____	☐ Heart Problems	Relation: _____
☐ Scoliosis	Relation: _____	☐ Back Problems	Relation: _____
☐ Headaches	Relation: _____	☐ Ulcers	Relation: _____

X _____ _____

Patient/Parent/Guardian Signature **Date**