Welcome

Patient Information

Date _____/_____/_____

Name_____

Prefer to be called_____

Address_____

City/State_____Zip_____

Phone: (h)_____(cell)_____

e-mail_____

Birth Date ___/___/_____ Age_____ ☐Male ☐Female

☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse_____

Do you have Children ☐ Yes ☐ No How Many? _____

Referred to this office by _____

Employment Information

Employer _____

Address_____

City/State_____Zip_____

Phone_____Ext_____

Occupation_____

Insurance Information

Ins Company_____

Type: ☐Health ☐Auto ☐Worker's Comp ☐ Medicare

*Please bring your insurance card and ID to your first visit

☐ I hereby authorize assignment of insurance benefits directly to provider for services rendered

Emergency Contact

Name_____

Relationship_____

Phone_____

Who is your medical Doctor?_____

Office location_____

Account Information

Person Responsible for Account_____

Relationship_____

Billing address if different from patient address

_____

City/State_____Zip_____

Phone_____

Patient Condition

Reason for visit _____ When did your symptoms begin? _____

Is this due to an accident? ☐ Yes ☐ No If Yes: ☐ Auto ☐ Work ☐ Sports ☐ Other _____

Have you had this condition before? ☐No ☐ Yes when_____

Describe your complaint and its location_____

Is it getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes ☐ Chronic

Rate your pain: 0 = no pain 10 = unbearable 0 1 2 3 4 5 6 7 8 9 10

Does it interfere with daily activities? ☐ No ☐ Yes explain_____

Do you have ☐ Numbness ☐ Tingling Location_____

What have you tried to relieve the problem(s)?_____

Have you seen anyone else for this condition? ☐No ☐Yes Who?_____

Have you ever been treated by a chiropractor? ☐ No ☐ Yes Dr's Name and location_____

Patient Health History

Are you currently taking any of the following? (Please list and give reason for taking)
Prescription medications_____
Over the counter medications_____
Vitamins/supplements_____
Do you currently have or have had any of the following diseases/medical condition? Check ☑ Yes or No

☐ Y ☐ N Heart attack
☐ Y ☐ N Congenital heart defect
☐ Y ☐ N High blood pressure
☐ Y ☐ N Low blood pressure
☐ Y ☐ N Headaches
☐ Y ☐ N Heart surgery
☐ Y ☐ N Pacemaker
☐ Y ☐ N Dizziness/Fainting
☐ Y ☐ N Anemia
☐ Y ☐ N Shingles
☐ Y ☐ N Prostate trouble
☐ Y ☐ N Appendicitis
☐ Y ☐ N Low back pain
☐ Y ☐ N Neck pain
☐ Y ☐ N Stroke
☐ Y ☐ N Difficulty Breathing
☐ Y ☐ N Emphysema
☐ Y ☐ N Asthma

☐ Y ☐ N Allergies
☐ Y ☐ N Sinus Trouble
☐ Y ☐ N Kidney problems
☐ Y ☐ N Venereal disease
☐ Y ☐ N Ulcers/Colitis
☐ Y ☐ N Diabetes
☐ Y ☐ N HIV/AIDS
☐ Y ☐ N Miscarriage
☐ Y ☐ N Vision problems
☐ Y ☐ N Thyroid problems
☐ Y ☐ N Arthritis
☐ Y ☐ N Gout
☐ Y ☐ N Polio
☐ Y ☐ N Chicken Pox
☐ Y ☐ N Scoliosis
☐ Y ☐ N Mental illness
☐ Y ☐ N Multiple sclerosis
☐ Y ☐ N Tuberculosis

☐ Y ☐ N Seizures/Epilepsy
☐ Y ☐ N Hepatitis
☐ Y ☐ N Fibromyalgia
☐ Y ☐ N Rheumatoid arthritis
☐ Y ☐ N Pneumonia
☐ Y ☐ N Hearing trouble
☐ Y ☐ N Digestive problems
☐ Y ☐ N Artificial joints _____
☐ Y ☐ N Pinched nerve
☐ Y ☐ N Fractures
☐ Y ☐ N Implants _____

☐ Y ☐ N Cancer/tumors *
* Type _____
Date of diagnosis_____
Treatment _____
Current status_____

Please list any other serious medical condition(s) you have ever had_____
_____
List any surgeries/treatment/hospitalizations with dates_____
_____
List any past serious accidents/injuries/broken bones/dislocations with dates_____
_____
Family health history_____
Do you participate in any physical activity? _____
Do you smoke? ☐ No ☐ Yes How much_____ How long _____ Do you drink alcohol? ☐ No ☐ Yes _____/week
Do you drink coffee/caffeine drinks? ☐ No ☐ Yes Cups/day_____
Do you have high stress levels? ☐ No ☐ Yes reason_____
Do you wear ☐ Heel lifts ☐ arch supports/orthotics Do you have foot pain? ☐ No ☐ Yes
Does your job require ☐ Sitting _____hrs ☐ Standing _____hrs ☐ Lifting _____lbs
Hours of sleep per night _____ Quality ☐ Good ☐ Fair ☐ Poor

For women:
Are you pregnant? ☐ No ☐ Yes _____weeks Due date _____ Nursing ☐ No ☐ Yes
Are you on birth control? ☐ No ☐ Yes _____

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

Patient / Guardian signature _____ Date _____/_____/_____