

Patient Information

Please Print

Name _____ Date _____ SS# _____
Address _____ City _____ State _____ Zip _____
 Male Female Married Single Widowed Divorced Separated
Birthdate _____ Home Phone _____ Cell _____
Work Phone _____ E-mail Address _____
Employer _____ Occupation _____ #years _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Birthdate _____ Phone _____
Emergency Contact _____ Phone _____ Relation _____
Whom may we thank for referring you to us? _____
Name of local primary Physician _____ May we contact them? _____

Insurance Information – If Insured, Please provide copy of insurance card

SYMPTOMS

Main Complaint _____ How Bad? _____ How Often? _____
When did it start? _____ Getting Worse? _____ Getting Better? _____
What activity bothers it the most? _____
When is it at its best? _____ When is it at its worst? _____
Rate the pain - (0 is pain free - 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10
Other Chiropractors? _____ Positive Experience? _____
Other type of physician or therapist? _____ Positive Experience? _____
Secondary Complaint _____

Health History - Please circle all that apply

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M. S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V. D.	Whooping Cough	
Chronic Fatigue	High Blood Pressure	Fibromyalgia	Other _____				

Women - How many children? _____ Pregnant? _____ Date of last Menstrual Cycle _____
Nursing? _____ Taking Birth Control Pills? _____
Previous Surgeries and Dates? _____

List ALL Medications you are currently taking _____

What kind of exercise do you do? _____

What supplements do you take? _____

How much do you smoke per day? _____ Drink per week? _____

***All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize- this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.**

Patient Signature _____ Date _____