

**CONFIDENTIAL PATIENT INFORMATION**

**PLEASE PRINT CLEARLY**

**DATE** \_\_\_/\_\_\_/\_\_\_

This information is confidential. If we do not sincerely believe your problem will respond favorably we will not be able to accept your case. We will refer you to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately and completely. Thank you.

**Name** \_\_\_\_\_ **SS#** \_\_\_\_\_ **Home Phone** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Email** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_

**Age** \_\_\_\_\_ **Birth Date** \_\_\_/\_\_\_/\_\_\_ **Marital Status** S M W D **Number of Children** \_\_\_\_\_ **Ages** \_\_\_\_\_

**Occupation** \_\_\_\_\_ **Employer** \_\_\_\_\_

**Address** \_\_\_\_\_ **Office Phone** \_\_\_\_\_

**Name of Wife or Husband or Guardian** \_\_\_\_\_ **Office Phone** \_\_\_\_\_

**Occupation** \_\_\_\_\_ **Employer** \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

**Have you ever seen a Chiropractor? yes no**

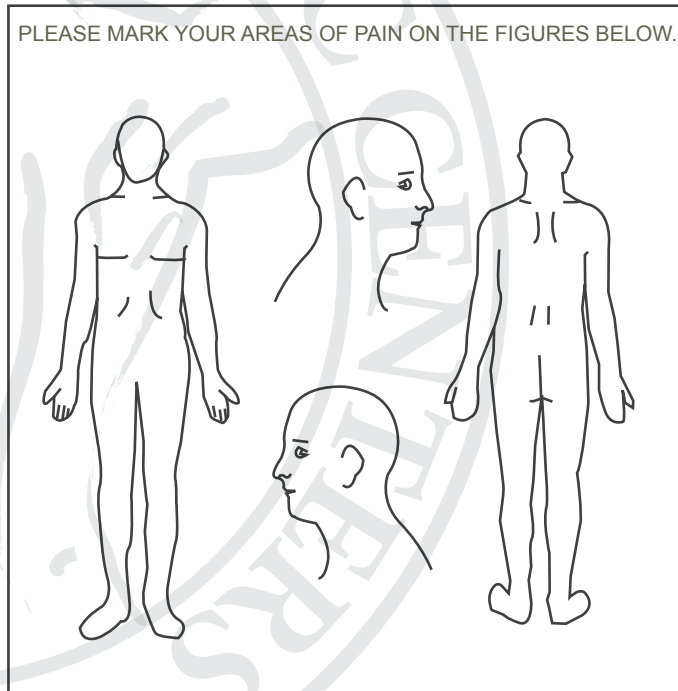
**My Chiropractor is/was** \_\_\_\_\_

**LIST PRESENT COMPLAINTS, INJURIES AND DURATION**

- 1. \_\_\_\_\_
- \_\_\_\_\_
- 2. \_\_\_\_\_
- \_\_\_\_\_
- 3. \_\_\_\_\_
- \_\_\_\_\_

**REMARKS AND DETAILS OF ANY ACCIDENT**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**LIST OTHER DOCTORS CONSULTED FOR PRESENT COMPLAINTS AND INJURIES.**

**Name** \_\_\_\_\_ **When Consulted** \_\_\_\_\_

**Diagnosis** \_\_\_\_\_ **Treatment** \_\_\_\_\_

**How Long Did You See The Doctor?** \_\_\_\_\_ **How Frequently?** \_\_\_\_\_

**Results** \_\_\_\_\_

**Name** \_\_\_\_\_ **When Consulted** \_\_\_\_\_

**Diagnosis** \_\_\_\_\_ **Treatment** \_\_\_\_\_

**How Long Did You See The Doctor?** \_\_\_\_\_ **How Frequently?** \_\_\_\_\_

**Results** \_\_\_\_\_

**Present Family Doctor** \_\_\_\_\_

**Date Of Last Physical Examination** \_\_\_\_\_

**By Doctor** \_\_\_\_\_

**PRIMARY SYMPTOMS**

**MUSCULO-SKELETAL**

- Recurring Headaches
- Eye or Sinus Pain
- Facial Spasms
- Facial/Jaw Pain
- Restricted Movement Head/neck
- Neck-Pain
- Neck Spasms
- Poor Posture
- Upper Back Pain
- Pain-shoulder/Arm/Hand
- Painful/stiff Joints
- Swollen Arm/Hand
- Restricted Movements Shoulder/Arm/Hand
- Arthritis
- Bursitis
- Pain Beneath/Under Shoulder Blade
- Pain Around Collar Bone
- Mid Back Pain
- Chest Pain
- Rib Cage Pain
- Pain Beneath/below Breast Bone
- Hiatal Hernia
- Scoliosis
- Low Back Pain
- Rheumatism
- Neuritis
- Neuralgia
- Lumbago
- Painful Tailbone
- Buttock Pain
- Hip Pain
- Sciatica
- Swollen/Painful/Stiff Joints Leg/Foot
- Leg Cramps
- Leg Pain Lower Upper
- Walking Problems

CIRCLE CURRENT CONDITIONS - CHECK FORMER CONDITIONS

**CORRELATING SYMPTOMS**

**NERVOUS SYSTEM**

- Hot/cold Spots
- Numbness/Tingling
- Dizziness
- Fainting
- Tremors
- Anxiety
- Irritability
- Hiccups
- Nervousness
- Personality Change

- Insomnia
- Depression
- Confusion
- Forgetfulness
- Tension

**EYE, EAR, NOSE & THROAT**

- Visual disturbances
- Dental problems
- Sinus trouble
- Vision problems
- Hoarseness
- Head Colds
- Hearing Loss
- Difficulty speaking
- Nose discharge
- Sore Throat
- Ear Noises

- Light Sensitivity
- Nose bleeding
- Hayfever/allergies
- Chronic earache
- Sore mouth/gums

**RESPIRATORY**

- Difficulty Breathing
- Chronic Cough

- Allergies
- Asthma

- Chest Colds
- Coughing Phelgm/blood

**CARDIO-VASCULAR**

- Heart Attack
- High Blood Pressure
- Low Blood Pressure
- Rapid Beating Heart

- Slow Beating Heart
- Pain Over Heart
- Hardening Of Arteries
- Swelling Of Ankles

- Poor Circulation
- Stroke
- Varicose Veins

**GASTRO-INTESTINAL**

- Chronic Nausea
- Gastritis/heartburn
- Pain Over Stomach
- Jaundice
- Black Stool
- Excessive Thirst

- Belching Gas
- Hemorrhoids
- Gall Bladder Trouble
- Excessive Hunger
- Diarrhea
- Colitis

- Vomiting
- Vomiting Blood
- Poor Appetite
- Constipation
- Bloody Stool

**SKIN**

- Skin disorder
- Acne
- Shingles

- Itching
- Bruise easily
- Dryness

- Boils
- Hives or allergies

**GENERAL**

- Fever
- Thyroid Disorder
- Chills
- Diabetes

- Sweats
- Rheumatic Fever
- Chronic Fatigue

- Cancer
- Loss Of Weight
- Weight Trouble

**GENITO-URINARY**

- Urine Disorder
- Kidney Infection/Stones
- Impotency

- Bladder Trouble
- Prostatitis

- Bed Wetting
- Discolored/blood/ Pus

**FEMALE**

- Periods Painful/excessive
- Irregular Cramps

- Hot Flashes
- Breast Lumps

- Menopause Symptoms

**PREGNANT YES OR NO**

What Surgeries Have You Had \_\_\_\_\_

List Broken Bones \_\_\_\_\_

List Former Serious Accidents And Falls \_\_\_\_\_

List Medications and Diet Supplements You Take \_\_\_\_\_

**WORK-** (Please circle appropriate answer)

**JOB INVOLVES** Lifting Bending Stooping Twisting Turning Carrying Walking Standing Other \_\_\_\_\_

**SEATED/STANDING** Work Bench Desk Counter Other \_\_\_\_\_

**SHOES** High Heel Boots Other \_\_\_\_\_

**CHAIR** Executive Steno Bench Stool Folding Other \_\_\_\_\_

**SEDENTARY ACTIVITIES** Standing Seated Lying TV Reading Card Games Sewing Other \_\_\_\_\_

**STRENUOUS ACTIVITIES** \_\_\_\_\_

**EXERT YOURSELF** Frequently Occasionally Rarely Never

**NOTES**

**CONSENT TO TREATMENT OF MINOR CHILD**

I hereby authorize:

Dr. \_\_\_\_\_ and whomever he or she may designate as assistants to administer chiropractic care as deemed necessary to my \_\_\_\_\_ (indicate relationship to child).

**Name of Child**

Date at \_\_\_\_\_, \_\_\_\_\_

**City**

**State**

this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

**Day**

**Month**

**Year**

\_\_\_\_\_  
**Signature of Parent or Guardian**

\_\_\_\_\_  
**Witness**

**FINANCIAL RESPONSIBILITY STATEMENT**

Understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, against the Doctor's recommendation, my account balance will be immediately due and payable.

**Patient's Signature** \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Other responsible party \_\_\_\_\_ SS# \_\_\_\_\_ Information taken by \_\_\_\_\_

**INSURANCE**

Primary Co. \_\_\_\_\_ Address \_\_\_\_\_

Deductible \$ \_\_\_\_\_ Already Paid Yes No Not Known Percentage Insurance Co. pays (if known) \_\_\_\_\_%

Insured \_\_\_\_\_ Ins. I.D.# \_\_\_\_\_ S.S.# \_\_\_\_\_

Insured's DOB \_\_\_\_\_

Other Co. \_\_\_\_\_ Address \_\_\_\_\_

Deductible \$ \_\_\_\_\_ Already Paid Yes No Not Known Percentage Insurance Co. pays (if known) \_\_\_\_\_%

Insured \_\_\_\_\_ Ins. I.D.# \_\_\_\_\_ S.S.# \_\_\_\_\_

Insured's DOB \_\_\_\_\_