

CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION:

FULL NAME _____ DATE OF BIRTH ____/____/____ AGE _____ Male Female
ADDRESS _____ APT # _____ SSN _____ - _____ - _____
CITY _____ STATE _____ ZIP CODE _____ HOME PHONE (____) _____
ALTERNATE PHONE (____) _____ E-MAIL ADDRESS _____
EMPLOYER'S NAME _____ OCCUPATION _____
WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____
WORK PHONE (____) _____ EXT. _____ MARITAL STATUS: SINGLE MARRIED WIDOWED
PRIMARY CARE PHYSICIAN _____
EMERGENCY CONTACT _____ PHONE _____
HOW DID YOU HEAR ABOUT US? _____

INSURANCE INFORMATION:

RELATIONSHIP TO INSURED? SELF SPOUSE OTHER CHILD INSURED'S NAME: _____
INSURED'S SSN: ____-____-____ SAME AS ABOVE INSURED'S DOB ____/____/____ SAME AS ABOVE
PRIMARY INSURANCE CO. _____ SECONDARY INSURANCE CO. _____

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

Patient's Signature: _____ Date: _____
Guardian Signature: _____ Date: _____

List the specific goals you would like to accomplish during our time together:

Describe your current level of health:

Describe the level of health you would like to be experiencing one year from today:

Describe any lifestyle changes that you think would help you achieve that goal:

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WHAT BRINGS YOU TO OUR OFFICE?

CHIEF COMPLAINT: _____

- Date complaint first appeared _____
- Did it begin _____ gradual _____ sudden
- What makes symptoms worse? _____
- What makes symptoms better? _____
- Type of pain _____ sharp _____ dull _____ ache _____ burning _____ throbbing
- Does the pain radiate into _____ arms _____ legs _____ does not radiate

ANY OTHER COMPLAINTS: _____

- Date complaint first appeared _____
- Did it begin _____ gradual _____ sudden
- What makes symptoms worse? _____
- What makes symptoms better? _____
- Type of pain _____ sharp _____ dull _____ ache _____ burning _____ throbbing
- Does the pain radiate into _____ arms _____ legs _____ does not radiate

PLEASE LIST ALL PAST HOSPITALIZATIONS

Reason _____	Date _____
Reason _____	Date _____
Reason _____	Date _____
Reason _____	Date _____

PLEASE LIST ALL PAST SURGERIES

Reason _____	Date _____	Doctor _____
Reason _____	Date _____	Doctor _____
Reason _____	Date _____	Doctor _____
Reason _____	Date _____	Doctor _____

PLEASE LIST ALL PAST ACCIDENTS AND FALLS

Type _____	Date _____
Type _____	Date _____
Type _____	Date _____

REASON FOR TREATMENT (Check all that apply): Wellness/Proactive Care Imbalance Pain Condition

Other _____

Have you had previous chiropractic care? _____ If so, how long ago? _____

Mark an "X" on the line to indicate your habits:

Drink more than 6 glasses of water per day _____ Drink coffee/sodas/alcohol _____

Balanced diet (fruits, veggies, Protein, grains) _____ Eat processed foods, fried foods, fast food _____

Frequent exercise/active _____ No exercise _____

Stretch _____ Do no stretch– inflexible _____

Feel rested after sleep _____ Un-rested/always tired _____

Anything you would like to add? _____

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Please check the appropriate box for any of the following symptoms, which you currently have (C) or have had in the past (P).

THIS IS A CONFIDENTIAL HEALTH REPORT

SYMPTOM	C	P	SYMPTOM	C	P	SYMPTOM	C	P
General			Gastro-Intestinal			Eyes, Ears, Nose & Throat		
Allergy			Belching or Gas			Asthma		
Chills			Colitis			Colds		
Convulsions			Colon trouble			Deafness		
Dizziness			Constipation			Dental decay		
Fainting			Diarrhea			Earache		
Fatigue			Distention of abdomen			Ear discharge		
Fever			Excessive hunger			Enlarged glands		
Headache			Gall bladder trouble			Enlarged thyroid		
Loss of sleep			Hemorrhoids			Eye pain		
Loss of weight			Jaundice			Nasal obstruction		
Nervousness/Depression			Liver trouble			Nosebleeds		
Neuralgia			Nausea/Vomiting			Sinus Infection		
Numbness			Poor appetite			Tonsillitis		
Sweats								
Tremors			Skin	C	P	Respiratory	C	P
			Boils			Chest pain		
Muscle & Joint	C	P	Bruise easily			Chronic cough		
Arthritis			Dryness			Difficult breathing		
Bursitis			Hives or Allergy			Spitting up blood		
Carpal Tunnel Syndrome			Itching			Spitting up phlegm		
Foot trouble			Rash			Wheezing		
Herniated disc								
Low back pain			Cardio-Vascular	C	P	Genito-Urinary	C	P
Neck pain or stiffness			Hardening of arteries			Bedwetting		
Pain or numbness in:			High blood pressure			Blood in urine		
Shoulders			Low blood pressure			Frequent urination		
Arms			Pain over heart			Unable to control bladder		
Elbows			Poor circulation			Kidney infection or stone		
Hands			Rapid heart beat			Painful urination		
Hips			Slow heart beat			Prostate trouble		
Legs			Swelling of ankles			Pus in urine		
Knees								
Feet			For Women Only	C	P		Y	N
Painful tail bone			Cramps or backache			Are You Pregnant?		
Poor posture			Excessive menstrual flow					
Sciatica			Hot flashes					
Spinal curvature/Scoliosis			Irregular cycle					
Swollen joints			Menopausal symptoms					
			Painful Menstruation					

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

Alcoholism	Chorea	Fever Blisters	Miscarriage	Scarlet Fever
Anemia	Cold Sores	Goiter	Multiple Sclerosis	Sexually Transmitted Disease
Appendicitis	Diabetes	Gout	Mumps	Stroke
Arteriosclerosis	Diphtheria	Heart Disease	Pleurisy	Tuberculosis
Arthritis	Eczema	Influenza	Pneumonia	Typhoid Fever
Cancer	Emphysema	Malaria	Polio	Ulcers
Chicken Pox	Epilepsy	Measles	Rheumatic Fever	Whooping Cough