Phone Number:

Patient Information

Date: _____ SSN: _____ Birthday: _____

First Name: _____ Middle Name: _____ Last Name: _____

Sex: ◯M ◯F Height: _____ Weight: _____

Marital Status: ◯Yes ◯No Spouse Name: _____ # of Children: _____

Home #: _____ Cell #: _____ Work #: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Emergency Relation: _____ Emergency Phone: _____

Email: _____

Referral Information

Referring Physician: _____ Referred Patient: _____ Referred by: _____

Advertisement: ◯Yes ◯No Advertisement: _____

Referred Directory: ◯Yes ◯No Referred Directory: _____

Employer Information

Employed: ◯Full Time ◯Part Time ◯Homemaker ◯Unemployed Employer Name: _____

Employer Address: _____

Employer City: _____ Employer State: _____ Employer Zip: _____

Occupation: _____ Work Supervisor: _____ Supervisor #: _____

Work Duties: _____

Insurance Information

Payment: ◯Personal ◯3rd Party ◯Self Resp. for Payment: _____ Responsible Phone : _____

Payment Name: _____ Primary Phone #: _____ Primary ID/Policy: _____

Payment Address: _____

Payment City: _____ Payment State: _____ Payment Zip: _____

Primary Group #: _____ Primary Name: _____ Primary DOB: _____

Secondary Name: _____ Secondary Phone #: _____ Secondary ID/Policy: _____

Secondary Address: _____

Secondary City: _____ Secondary State: _____ Secondary Zip: _____

Secondary Group #: _____ Secondary Name: _____ Secondary DOB: _____

Claim #: _____ Claim Contact: _____ Claim Phone #: _____

Attorney Name: _____ Attorney Phone #: _____

Complaint Information

Injury Occurred: ◯Automobile ◯Work ◯Third-Party ◯Other Injury Date: _____

Injury Origin: _____

Desc Discomfort: _____

Frequency: ◯Always ◯Hourly ◯Daily ◯Occasionally

Interfere w/ Activities: ◯Yes ◯No Affected Sleep: ◯Yes ◯No

Missed Work: ◯Yes ◯No Unable to Work from: _____ Unable to Work til: _____

Affected Appetite: ◯Yes ◯No Explain: _____

Reduced Work: ◯Yes ◯No Explain: _____

Does it Worsen: ◯Yes ◯No Explain: _____

Weather Affects it: ◯Yes ◯No Explain: _____

Aggravates Condition: _____

Improves Condition: _____

Received Treatment: ◯Yes ◯No Explain: _____

X-rays Taken: ◯Yes ◯No Explain: _____

Same Condition Before: ◯Yes ◯No Date: _____ Practitioner: _____

History

Last Physical Exam: _____ Primary Phys: _____ Phys Phone #: _____

Phys City: _____ Phys State: _____ Phys Zip: _____

Health Conditions: _____

Previous Chiro Care: ◯Yes ◯No Date: _____ Explain: _____

Chance Pregnant: ◯Yes ◯No Planning: ◯Yes ◯No

Medications: _____

Supplements: _____

Broken Bones: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: _____

Sprains/Strains: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: _____

Hospitalized: ◯Yes ◯No Explain: _____

Surgery: ◯Yes ◯No Explain: _____

Auto Accident: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: _____

Struck Unconscious: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: _____

Eating Disorder: ◯Yes ◯No Explain: _____

Stroke: ◯Yes ◯No Explain: _____

Family Health Hist: _____

Patient Social

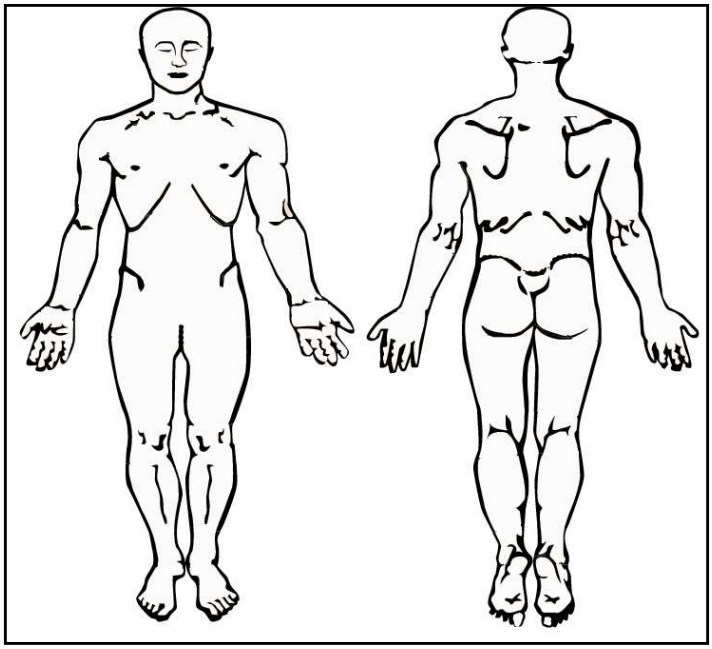
Alcohol:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Caffeine:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Diet Food Products:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Drugs:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
OTC Stimulants:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Exercise:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Homemade Food:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Processed Food:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Soft Drinks:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Tobacco:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Water:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never					

Health Checklist

☐ Allergies	☐ Alcoholism	☐ Anemia
☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Breast Lump	☐ Bronchitis
☐ Bruise Easily	☐ Cancer	☐ Chest Pain
☐ Cold Extremities	☐ Constipation	☐ Cramps
☐ Depression	☐ Diabetes	☐ Digestion Problems
☐ Dizziness	☐ Excessive Menstruation	☐ Eye Pain or Difficulties
☐ Fatigue	☐ Frequent Urination	☐ Headache
☐ Hemorrhoids	☐ High Blood Pressure	☐ Hot Flashes
☐ Irregular Heart Beat	☐ Irregular Menstrual Cycle	☐ Kidney Infection
☐ Kidney Stones	☐ Loss of Memory	☐ Loss of Balance
☐ Loss of Smell	☐ Loss of Taste	☐ Nosebleeds
☐ Pacemaker	☐ Polio	☐ Poor Posture
☐ Prostate Trouble	☐ Sciatica	☐ Shortness of Breath
☐ High Blood Pressure	☐ Sinus Infection	☐ Insomnia
☐ Spinal Curvatures	☐ Stroke	☐ Swelling of Ankles
☐ Swollen Joints	☐ Thyroid Condition	☐ Tuberculosis
☐ Ulcers	☐ Varicose Veins	☐ Venereal Disease

☐ Other: _____

Patient Symptoms:



I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: _____ Date: _____