Patient Information

Date ______________________

____

Last Name First Name MI

Address ____

____

City State Zip Code

Cell (______)______________________ Home (_______)____________________

Email: ____

DOB _______/_______/___________ SS# __________________________

Sex ☐ Male ☐ Female ☐ Married ☐ Widowed ☐ Single

Patient Employer ____

Work Phone (________) ______________________________ Ext. ____________

Occupation: ____

Emergency Contact ____

Phone (_______) ___________________ Relation to Patient: ________________

How did you hear about us? ____________________________________

Insurance Information

Who is responsible for the account? ☐ Self (patient) ☐ Other

Name of other responsible person: ______________________________

Relationship to Patient? _______________________________________

Insurance Co. ____

Member # ___________________________Group #________________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Secondary insurance company:___________________________________

Group # ____

Subscriber's Name:____

Relationship to Patient: _______________________________________

Subscriber's DOB _________/_________/__________

SS#_______________________________________

Patient Condition

(1) Do you have ☐ Headaches ☐ Migraines

If so, how often? ____

(2) Reason for this visit? ______________________________________

____

(3) When did your symptoms appear? ______________________________

Patient Application

(14) What treatment have you already received for your condition?

☐Medications ☐Surgery ☐Physical Therapy ☐Chiropractic Services ☐None ☐Other

(15) Name of the doctor(s) who have treated you for your condition:

____

(16) Date of last:

Physical Exam: _________________ Spinal X-Ray: _____________________

Blood Test: _____________________ Spinal Exam: ____________________

Chest X-Ray: ____________________ Dental X-Ray: ____________________

MRI, CT-Scan, Bone Scan: ____

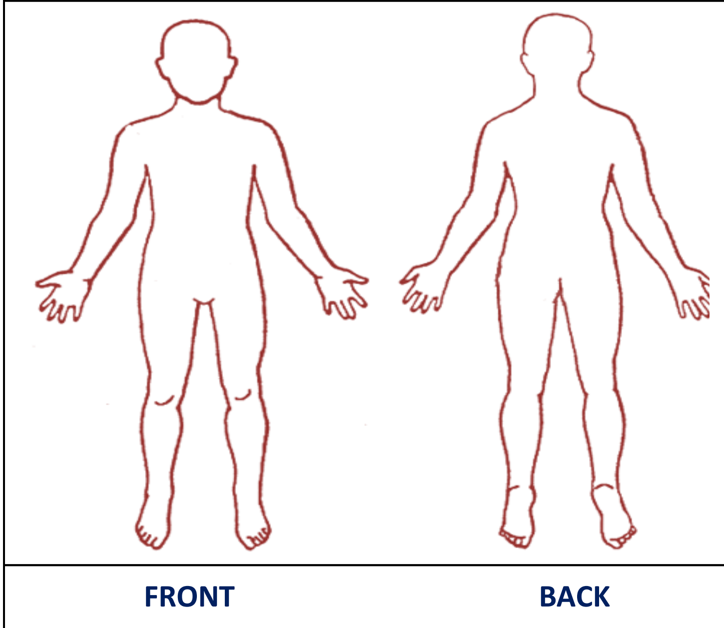
(17) Place a mark on "Yes" to indicate if you have or had any of the following:

AIDS/HIV	☐ Yes	Epilepsy	☐ Yes
Alcoholism	☐ Yes	Fractures	☐ Yes
Allergy Shots	☐ Yes	Glaucoma	☐ Yes
Anemia	☐ Yes	Goiter	☐ Yes
Anorexia	☐ Yes	Gout	☐ Yes
Appendicitis	☐ Yes	Hepatitis	☐ Yes
Arthritis	☐ Yes	Hernia	☐ Yes
Asthma	☐ Yes	Herniated Disk	☐ Yes
Bleeding Disorder	☐ Yes	Herpes	☐ Yes
Breast Lump	☐ Yes	High Bl. Pressure	☐ Yes
Bronchitis	☐ Yes	High Cholesterol	☐ Yes
Bulimia	☐ Yes	Kidney Disease	☐ Yes
Cancer	☐ Yes	Liver Disease	☐ Yes
Cataracts	☐ Yes	Measles	☐ Yes
Chemical Depend.	☐ Yes	Migraines	☐ Yes
Chicken Pox	☐ Yes	Miscarriage	☐ Yes
Diabetes	☐ Yes	Mono	☐ Yes
Emphysema	☐ Yes		

(Continued on back page)

(4) Is this symptom progressively worse? ☐Yes ☐No

Mark an X on the picture where you continue to have pain, numbness, or tingling.



FRONT **BACK**

(5) Rate the severity of your pain on a scale from 1 (least) to 10 (severe) _____

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Burning ☐Tingling ☐Cramping ☐Stiffness ☐Swelling

(6) How often do you have this pain? ________________________________

(7) Is it constant or does it come and go? ____________________________

(8) Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation

(9) Activities that are painful to perform: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down

Accident Information

(10) Are any of the above conditions due to an accident? ☐Yes ☐No

(11) Type of Accident: ☐Auto ☐Work ☐Home ☐Other (please explain below)

____

____

(12) Attorney Name (if applicable): ___________________________________

____

(13) Attorney Telephone: ____

Multiple Sclerosis	☐ Yes	Rheumatoid Arthritis	☐ Yes
Mumps	☐ Yes	Rheumatic Fever	☐ Yes
Osteoporosis	☐ Yes	STD	☐ Yes
Pacemaker	☐ Yes	Stroke	☐ Yes
Parkinson's	☐ Yes	Suicide Att.	☐ Yes
Pinched Nerve	☐ Yes	Thyroid Problem	☐ Yes
Pneumonia	☐ Yes	Tonsillitis	☐ Yes
Polio	☐ Yes	Tuberculosis	☐ Yes
Prostate Problem	☐ Yes	Tumors	☐ Yes
Prosthesis	☐ Yes	Typhoid Fever	☐ Yes
Psychiatric Care	☐ Yes	Ulcer	☐ Yes
		Vaginal Infection	☐ Yes

Other: ____

(20) Exercise Habits: ☐None ☐Moderate ☐Daily ☐Heavy

(21) Work Activity: ☐Sitting ☐Standing ☐Light ☐Heavy

(22) Other Habits ☐Smoking Packs/Day ________ ☐Drinking

Drinks/Week________ ☐Caffeine Cups/Day ________

☐ High Stress? ______________________

(23) Are you pregnant? ☐Yes ☐No Due Date? ______________________

(24) Injuries/Surgeries you have had. Describe each:

Fall ____

Head Injury ____

Surgery ____

Broken Bones ____

Dislocations ____

(25) Medications you are currently taking:

____

____

(26) Allergies: ____

(27) Vitamin/Herb Supplements: ________________________________

____

Patient Signature: ____

Date: _________________