

Confidential Patient Information

(Please Print)

Patient Information

Dr./Mr./Mrs./Ms./Miss (circle one)

Marital status (circle one) M S W D

Acct# _____

Last Name	First Name	Middle Initial	Nick Name
Address	City	State	Zip Code
Home phone#	Cell Phone#		
Email address			
Social Security No.	Date of Birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F
Occupation	Employer		
Work Address			
Work Phone#			
Person to contact in an emergency	Phone#		

Responsible Party

Name of person responsible for payment of this account _____
Relationship to patient _____ Phone# _____

Address _____ City _____ State _____ Zip Code _____

Insurance Company: _____

Please provide the staff with your insurance card and/or necessary forms.

Symptoms

1. What is your **number one** problem or the **one area** of greatest pain? _____

2. Please rate the level of this pain on the following scale: **0 is no pain, 10 is severe pain** or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain.

0 1 2 3 4 5 6 7 8 9 10

3. When did this problem/pain start? _____ Gradual Sudden Progressive

4. What do you think caused this problem? _____

5. How often do you experience the pain?

___ 1-2 hours per day ___ About half of the day
___ Most of the day ___ The pain never goes away

6. How does the pain effect your daily activities?

___ It does not effect my daily activities ___ I have had to change how I do things
___ I have had to stop doing some of my daily activities ___ I am unable to perform daily activities

7. What **increases** your pain? _____

8. What **decreases** your pain? _____

9. Have you ever experienced this problem before? Y N When? _____

10. List any **other** complaints currently bothering you and rate your pain level for each.

a. _____	0	1	2	3	4	5	6	7	8	9	10
b. _____	0	1	2	3	4	5	6	7	8	9	10
c. _____	0	1	2	3	4	5	6	7	8	9	10
d. _____	0	1	2	3	4	5	6	7	8	9	10

11. Have you ever been involved in an automobile accident? Y N When? _____

Were you injured? Y N Explain _____

12. Have you ever been injured at work? Y N When? _____
Explain _____

13. List all medication you are currently taking (*prescribed and over the counter*) _____

14. List all surgeries you have had (*with date*) _____

If you have experienced any of the following conditions in the past mark a "P" on the line provided. If you are currently experiencing any of the following conditions please mark a "C" on the line provided. (*check all that apply*)

<input type="checkbox"/> heart attack	<input type="checkbox"/> stroke	<input type="checkbox"/> arthritis	<input type="checkbox"/> gall bladder trouble
<input type="checkbox"/> diabetes	<input type="checkbox"/> glaucoma	<input type="checkbox"/> fainting spells	<input type="checkbox"/> kidney stones
<input type="checkbox"/> difficulty with urination	<input type="checkbox"/> bloody stools	<input type="checkbox"/> difficulty with bowel movements	
<input type="checkbox"/> prostate trouble	<input type="checkbox"/> anemia	<input type="checkbox"/> cancer	<input type="checkbox"/> asthma
<input type="checkbox"/> AIDS	<input type="checkbox"/> ulcers	<input type="checkbox"/> diverticulosis	<input type="checkbox"/> menstrual cramping
<input type="checkbox"/> dizziness	<input type="checkbox"/> loss of memory	<input type="checkbox"/> chest pain	<input type="checkbox"/> shortness of breath
<input type="checkbox"/> constipation	<input type="checkbox"/> diarrhea	<input type="checkbox"/> general fatigue	<input type="checkbox"/> sudden weight loss
<input type="checkbox"/> nausea	<input type="checkbox"/> muscle cramping	<input type="checkbox"/> soreness in joints	<input type="checkbox"/> loss of hearing
<input type="checkbox"/> ears ringing	<input type="checkbox"/> headache	<input type="checkbox"/> migraine	<input type="checkbox"/> epilepsy
<input type="checkbox"/> gout	<input type="checkbox"/> tuberculosis	<input type="checkbox"/> syphilis	<input type="checkbox"/> sprained ankle <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> knee/hip replacement	<input type="checkbox"/> broken bones (<i>specify</i>) _____		

General Activities (*check all that apply*)

<input type="checkbox"/> sleep on waterbed	<input type="checkbox"/> read in bed	<input type="checkbox"/> fall asleep in recliner/on couch
<input type="checkbox"/> sleep on stomach	<input type="checkbox"/> needlepoint/knitting	<input type="checkbox"/> use two or more pillows to sleep with
<input type="checkbox"/> sewing	<input type="checkbox"/> lift weights/wt. mach.	<input type="checkbox"/> play video games (_____ hrs per day)
<input type="checkbox"/> exercise _____ x/wk	<input type="checkbox"/> jog _____ x/wk	<input type="checkbox"/> computer use (_____ hrs per day)
<input type="checkbox"/> swim	<input type="checkbox"/> use healthrider	<input type="checkbox"/> watch television (_____ hrs per day)

Please add anything else you would like the doctor to know: _____

Authorization

I certify that I have read and I understand the above information. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefit's otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____ **Date** _____

(Signature of parent if the patient is a minor)

Doctor's
Comments: _____

