Confidential Patient Information

(Please Print)

Patient Information **Acct#**_____

Dr./Mr./Mrs./Ms./Miss ***(circle one)*** **Marital status** *(circle one)* M S W D

_____

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 [ ] M [ ] 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)*

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

General Activities *(check all that apply)*

___ cell phone use (_____ hrs per day)	___ read in bed	___ fall asleep in recliner/on couch
___ sleep on stomach	___ sewing/crochet	___ use two or more pillows to sleep with
___ swim	___ needlepoint/knitting	___ play video games (_____ hrs per day)
___ exercise _____x/wk	___ jog _____x/wk	___ computer use (_____ hrs per day)
___ lift weights/wt machine	___ use exercise bike	___ 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:_____

_____

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