Patient Information

Name (printed): ______________________________________ Birthdate: ___________
Address: ______________________________ City: _________ State: ___ Zip: ________
Phone #'s: Cell ________________ Home ________________Work ________________
E-mail Address: ___________________________
☐ Male ☐ Female ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated
Whom may we thank for referring you to us? ______________________________
Employer: _______________________ Occupation: _____________________ #years: ____
Name of local primary Physician: _______________________ May we contact them? Y/N
Spouse/Parent's Name: _____________________ Birthdate: ______ Phone: ____________

Insurance Information – If insured, please provide copy of insurance card.

What brings you to our clinic?

Main Complaint: ____
What do you believe to be the cause? ____
When did it start? _____________________ Getting better or worse? ____________________
What activity bothers it the most? ____
When is it at its best? __________________ When is it at its worst? ____________________
Rate the pain: **NO PAIN** 0 1 2 3 4 5 6 7 8 9 10 **WORST PAIN**
Other Chiropractors? ____________________ Positive Experience? ____________________
Other type of physician or therapist? ________________ Positive Experience? ____________
Secondary Complaint: ____

Health History - Please circle all that apply.

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken Pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M. S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V. D.	Whooping Cough	
Chronic Fatigue	Fibromyalgia	High Blood Pressure		Other____________________			

Previous Surgeries and Dates? ____
____
What kind of exercise do you do? ____
What supplements do you take?____
History of smoking?____

* All questions above have been answered accurately; I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services, and I will be responsible for any outstanding amount owed this office.

Patient Signature: ______________________________ Date: _______________