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#________ Pager#________ 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 Information

If you have any insurance information 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

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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)*

___ sleep on waterbed ___ read in bed ___ fall asleep in recliner/on couch
___ sleep on stomach ___ needlepoint/knitting ___ use two or more pillows to sleep with
___ sewing ___ lift weights/wt. mach. ___ play video games (________ hrs per day)
___ exercise ______x/wk ___ jog ______x/wk ___ computer use (________ hrs per day)
___ swim ___ use healthrider ___ 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 to the best of my knowledge. 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 benefits 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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Body Diagram

Acct#____________

Last Name______________________________ First Name______________________________

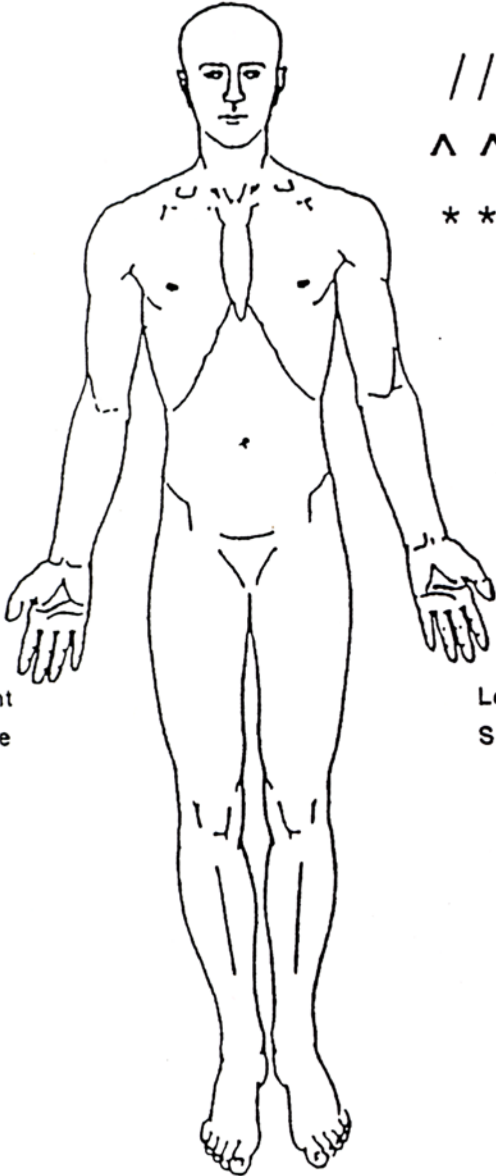
XXX Sharp Pain

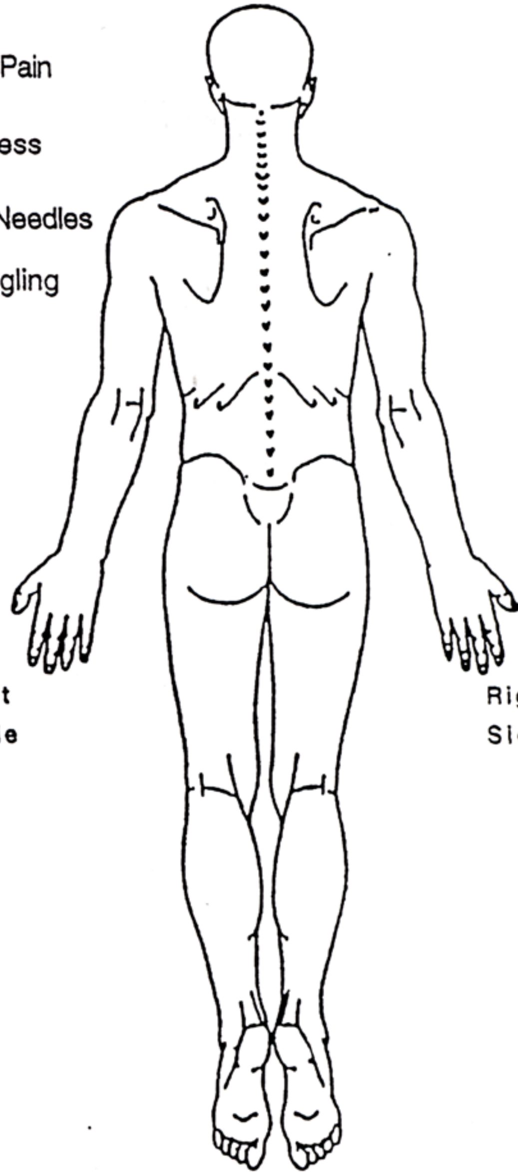
OOO Dull Ache

/ / / Burning Pain

Λ Λ Λ Numbness

* * * Pins & Needles or Tingling





Patient Signature ____ Date ________________

(Signature of parent if the patient is a minor)