Confidential Patient information

(Please Print)

Patient Information

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

_____

Last Name First Name Middle Initial

_____

Address City State Zip Code

Home Phone # _____Cell Phone # _____

E-mail address _____

Social Security # _____ 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 patient _____

Relationship to patient _____ Phone # _____

_____

(Address if different from above) City State Zip Code

How did you hear about us: _____

Symptoms

What is your number one problem or one area of greatest pain? _____

_____

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**

When did this problem/pain start? _____ [ ] Gradual [ ] Sudden [ ] Progressive

What do you think caused this problem? _____

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

How does the pain effect your daily activities?

___ It does not effect my daily activities. **___ I have had a to change how I do things**

___ I have had to stop doing some of my daily activities **___ I am unable to perform daily activities**

What increases your pain? _____

What decreases your pain? _____

Have you ever experienced this problem before? [ ] No [ ] Yes When? _____

Patient Name: _____ **Date: _____**

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

Have you been involved in an automobile accident? No [ ] Yes [ ] When? _____

Were you injured? No [ ] Yes [ ] Explain_____

Have you ever been injured at work? No [ ] Yes [ ] When? _____

Explain _____

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

_____

List all surgeries you have had (with dates) _____

_____

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)

Blood Sugar

___ excessive appetite
___ get shaky if hungry
___ hungry between meals
___ heart palpitates if meals missed
___ fatigue, eating relieves
___ lightheaded if meals delayed
___ afternoon headaches
___ overeating sweets upsets
___ overeating sweets upsets
___ crave candy or coffee in afternoons
___ moods of depression – "blues or melancholy
___ abnormal craving for sweets or snacks

Digestion

___ indigestion ½ - 1 hours after eating; may be up to 3-4 hours
___ acid reflux

Thyroid

___ increase in weight **___ decrease in weight** **___ fatigue easily** **___ ringing in ears**
___ sleepy during day **___ sensitive to cold** **___ dry or scaly skin** **___ constipation**
___ menal sluggishness **___ hair coarse, falls out** **___ slow pulse, below 65**
___ headaches upon arising **___ impaired hearing** **___ reduced initiative**
___ frequency of urination

Adrenals

___ weakness, dizziness **___ chronic fatigue** **___ low blood pressure** **___ nails weak, ridged**
___ arthritic tendencies **___ perspiration increase** **___ bowel disorders** **___ poor circulation**
___ swollen ankles **___ crave salt** **___ brown spots or bronzing of skin**
___ allergies- tendency to asthma **___ weakness after colds, influenza**
___ exhaustion – muscular and nervous **___ respiratory disorders**

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 pillows or more 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)

Do you have a family history of the following? **(check all that apply)**

___ Arthritis	___ High Blood Pressure	___ High Cholesterol
___ Diabetes	___ Heart Disease	___ Cancer
___ Chronic Pain		

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 that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents.

Primary **Insurance Company Name: _____ Phone # _____**
ID # _____ Group # _____

Secondary **Insurance Company Name: _____ Phone: _____**
ID # _____ Group # _____

Name: _____ Date: _____
(Please Print)

Signature

(Signature of parent if patient is a minor)