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We Help Your Body Heal Itself

OPTIMUM HEALTH THROUGH CHIROPRACTIC CARE

(CONFIDENTIAL)

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ S/S _____

Address _____ City _____ State _____ Zip _____

Sex: Female Male Birthdate _____ Age _____

Home Phone # _____ Cell # _____ Work Phone # _____

Do you prefer to receive calls at: Home Work Cell All

Are you: Minor Married Divorced Single Separated

Your Employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's or Parent's Name _____ Work Place _____ Work Phone # _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

Responsible Party

Name of person responsible for this account? _____

Relationship to Patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of Employer _____ Work Phone # _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birth Date _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Phone # (____) _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Current Health Condition

Reason for visit _____ When did you first notice the symptoms? _____

Is this condition getting progressively worse? _____

Where specifically is the problem(s) located? _____

Is this condition interfering with work? Sleep? Routines? Other?

Which activities are difficult to perform? Sitting Standing Walking Bending Lying Down Other

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling Other

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What activities aggravate your condition/pain? _____

What treatment have you already received for your condition? Medication Surgery Physical Therapy Other

Other Symptoms

- | | | | | |
|---------------------------------------------|---------------------------------------|----------------------------------------|------------------------------------------------|------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Tension | <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Fainting | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Arm pain |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness fingers/toes | <input type="checkbox"/> Leg pain |

Health History

Check only those conditions which are applicable:

- | | | | | |
|---------------------------------------------|----------------------------------------------|---------------------------------------------|-----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Aids / HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke | _____ |

Dates of last exams _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

List any types of surgeries which you have had and the dates which they occurred:

Please list all medications you are currently taking: _____

Allergies: _____

Daily Habits

What type of exercise do you perform on a daily basis? None Moderate Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

Do you smoke? No Yes How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

As a result of my chiropractic care, I would like to: (please check all that apply)

- Feel better quickly Have a healthier body Have a healthier life Live life without limits

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and records of any treatment or examination tendered 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 the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

SIGNATURE OF PATIENT (or parent if minor)

DATE