

# Confidential Patient Information

(Please Print)

## Patient Information

Dr./Mr./Mrs./Ms./Miss (circle one)

Acct# \_\_\_\_\_

Marital Status (circle one) M S W D

\_\_\_\_\_  
Last Name First Name Middle Initial Nick Name

\_\_\_\_\_  
Address City State Zip Code

Mobile phone# \_\_\_\_\_ Home 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 you 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. _____ | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> | <b>7</b> | <b>8</b> | <b>9</b> | <b>10</b> |
| b. _____ | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> | <b>7</b> | <b>8</b> | <b>9</b> | <b>10</b> |
| c. _____ | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> | <b>7</b> | <b>8</b> | <b>9</b> | <b>10</b> |
| d. _____ | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> | <b>7</b> | <b>8</b> | <b>9</b> | <b>10</b> |

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) \_\_\_\_\_

15. Please provide your medical doctors name \_\_\_\_\_

16. Please provide any previous chiropractors you have treated with \_\_\_\_\_

If you have experienced any of the following conditions in the past mark with 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             |
| ___bloody stools                   | ___cancer                | ___asthma                     | ___difficulty with urination |
| ___prostate trouble                | ___anemia                | ___AIDS                       | ___ulcers                    |
| ___diverticulitis                  | ___dizziness             | ___chest pain                 | ___menstrual cramping        |
| ___loss of memory                  | ___constipation          | ___diarrhea                   | ___shortness of breath       |
| ___general fatigue                 | ___nausea                | ___muscle cramping            | ___sudden weight loss        |
| ___ears ringing                    | ___headache              | ___soreness in joints         | ___loss of hearing           |
| ___migraine                        | ___epilepsy              | ___gout                       | ___tuberculosis              |
| ___syphilis                        | ___knee/hip replacement  | ___sprained ankle [ ] R [ ] L |                              |
| ___difficulty with bowel movements | ___broken bones(specify) | _____                         |                              |

**General Activities** (check all that apply)

- |                                            |                                                 |                                                             |
|--------------------------------------------|-------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> sleep on waterbed | <input type="checkbox"/> read in bed            | <input type="checkbox"/> fall asleep in recliner/on couch   |
| <input type="checkbox"/> sleep on stomach  | <input type="checkbox"/> needlepoint/knitting   | <input type="checkbox"/> use two or more pillows to sleep   |
| <input type="checkbox"/> sewing            | <input type="checkbox"/> lift weights.wt. mach. | <input type="checkbox"/> play video games ( ___hrs per day) |
| <input type="checkbox"/> jog ___x/wk       | <input type="checkbox"/> swim                   | <input type="checkbox"/> computer use ( ___hrs per day)     |
| <input type="checkbox"/> exercise ___x/wk  | <input type="checkbox"/> use treadmill          | <input type="checkbox"/> 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 my child or me 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_