

# WELCOME

*"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in cause and prevention of disease." — Thomas Edison*

## 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 \_\_\_\_\_ Patient No. \_\_\_\_\_ S/S \_\_\_\_\_

First MI Last

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

Sex:  Female  Male

Birth date \_\_\_\_\_ Home phone # \_\_\_\_\_ Work phone # \_\_\_\_\_

Do you prefer to receive calls at:  Home  Work  Either

Are you:  Minor  Married  Divorced  Widowed  Single  Separated

Your employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's or parent's name \_\_\_\_\_ Workplace \_\_\_\_\_ 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 \_\_\_\_\_

## 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 # \_\_\_\_\_

DO YOU HAVE ADDITIONAL INSURANCE?  No  Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_ Date employed \_\_\_\_\_

Name of employer \_\_\_\_\_ Work phone # \_\_\_\_\_

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

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Employer # \_\_\_\_\_

# Symptoms

Reason for visit \_\_\_\_\_ When did you first notice the symptoms? \_\_\_\_\_

What treatment have you already received for your condition?

Medication     Surgery     Physical Therapy     Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition:

## 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? \_\_\_\_\_

## 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 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 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 for 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 a minor)

\_\_\_\_\_  
DATE

# Health Concerns

Name \_\_\_\_\_

Date \_\_\_\_\_

Please list your health problems/concerns below in order of importance.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

# NECK PAIN SCALE AND DIAGRAM

NAME (Please Print): \_\_\_\_\_ DATE: \_\_\_\_\_

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

HOW LONG HAVE YOU HAD NECK PAIN? \_\_\_\_\_ YEARS \_\_\_\_\_ MONTHS \_\_\_\_\_ WEEKS

IS THIS YOUR FIRST EPISODE OF NECK PAIN? \_\_\_\_\_ YES \_\_\_\_\_ NO

**USE THE LETTERS ON THE DIAGRAM BELOW  
TO INDICATE THE TYPE AND LOCATION OF THE  
SENSATIONS THAT YOU ARE HAVING RIGHT NOW**

**A = ACHE**

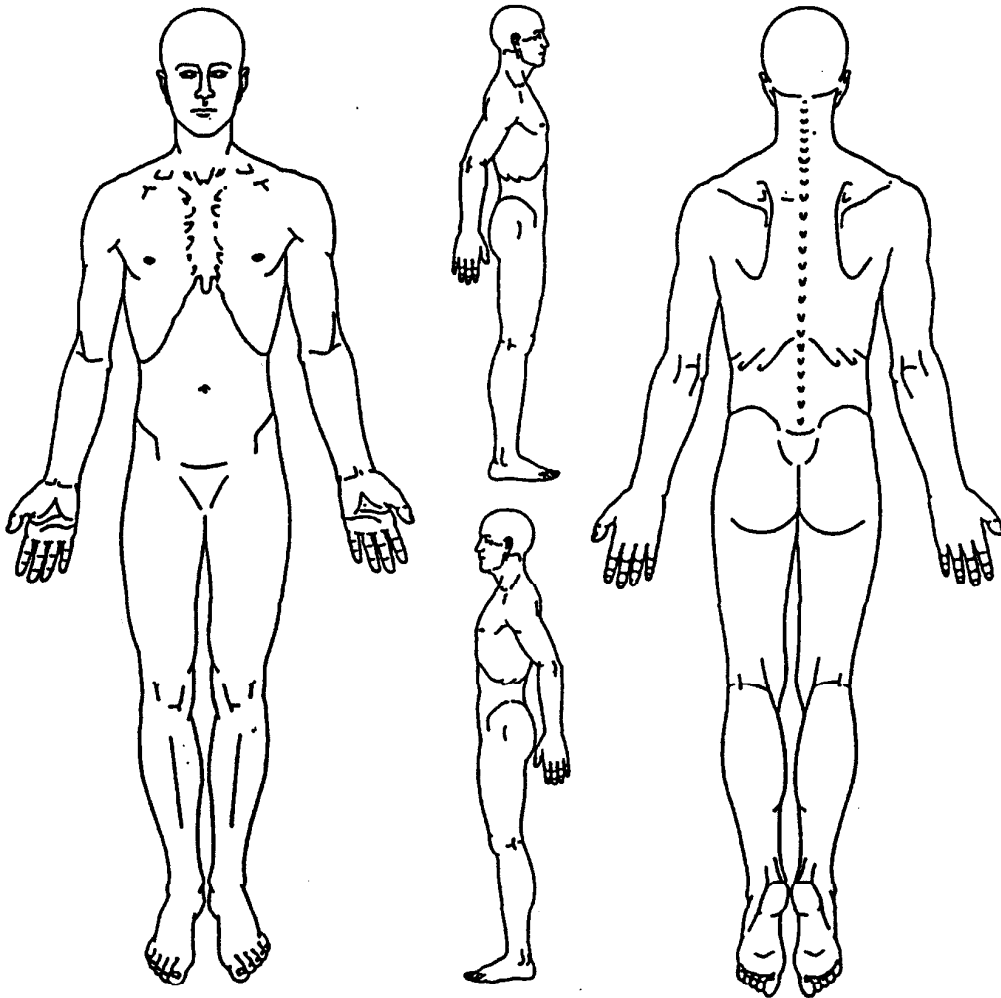
**B = BURNING**

**N = NUMBNESS**

**P = PINS & NEEDLES**

**S = STABBING**

**O = OTHER**



**Pain Severity Scale: Rate the Severity of your pain by checking one box on the following scale**

No Pain	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="padding: 5px 10px;">0</td> <td style="padding: 5px 10px;">1</td> <td style="padding: 5px 10px;">2</td> <td style="padding: 5px 10px;">3</td> <td style="padding: 5px 10px;">4</td> <td style="padding: 5px 10px;">5</td> <td style="padding: 5px 10px;">6</td> <td style="padding: 5px 10px;">7</td> <td style="padding: 5px 10px;">8</td> <td style="padding: 5px 10px;">9</td> <td style="padding: 5px 10px;">10</td> </tr> </table>	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain
0	1	2	3	4	5	6	7	8	9	10			