Welcome

We are pleased to welcome you to our Chiropractic practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you. We look forward to working with you in maintaining your health.

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip code:_____

Cel phone: _____Email:_____

Sex: [ ] M, [ ] F Age: _____ Birthdate: _____ [ ] Single, [ ] Married, [ ] Divorced, [ ] Widowed [ ] Separated

Employer's Name: _____ Occupation: _____

Whom may we thank for referring you? _____

Emergency contact: _____ phone: _____

Reason for Visit:

Location:	Intensity: 0-10 0= no pain, 10= worst pain	How long with pain?	Type of pain: Sharp, dull, aching, stiffness, throbbing?	Frequency: Constant, frequent, occasional?	Better with: ice, heat, rest, lying, ointment, medication, etc.	Worse with: walking, sitting, standing, lying, lifting
Neck						
Upper back						
Mid back						
Lower back						
Shoulder						
Knee						
Other:						
Other:						

Does the pain radiate? [ ] no, [ ] yes; _____

How is the pain interfering with your life? [ ] can't work, [ ] can't sleep well, [ ] can't exercise, [ ] _____

Due to trauma: (fall, car accident, work)? [ ] no, [ ] yes; _____

Have you seen another doctor for this condition? [ ] no, [ ] yes;_____

Are you taking any medication? [ ] no, [ ] yes; _____

Have you had any surgeries? _____

Please list any serious injuries you have had in the last 10 years:

Falls: _____

Head injuries: _____ Broken bones: _____

Car Accidents: _____ Work injuries: _____

Medical History:

[ ] high blood pressure, [ ] Diabetes, [ ] Cancer, [ ] Thyroid, [ ] Stroke, [ ] Arthritis, [ ] Psychiatric Illness. [ ] Ulcers, [ ] Heart disease, [ ] Vascular illness, [ ] Kidney disease, [ ] other: _____

Any allergies to medications or other? [ ] no, [ ] yes: _____

Please list the medications you currently take: [ ] no medication, [ ] _____

_____

Social History:

[ ] Working, [ ] Unemployed, [ ] Retired, [ ] Student,

[ ] Smoker, [ ] Non-Smoker, [ ] Ex-smoker, how long?_____,

[ ] consume alcoholic drinks [ ] yes, [ ] no, [ ] on social occasions only.

Family History:

Mother: [ ] alive, [ ] deceased, [ ] Medical condition: _____

Father: [ ] alive, [ ] deceased, [ ] Medical condition: _____

Brother/Sister: [ ] alive, [ ] deceased, [ ] Medical condition: _____

Brother/Sister: [ ] alive, [ ] deceased, [ ] Medical condition: _____

Primary Insurance

Are you the primary insured? [ ] yes, [ ] no, If no, who is the primary insured?_____

Your relationship to the primary insured? [ ] child, [ ] spouse, [ ] other:_____

Primary Insured's Date of Birth? _____

Ins. Co:_____ ID#_____ Phone:_____

Authorization: I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the chiropractor to release all

information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Signature: _____ Date:_____

Witness: _____ Date: _____