Patient Health Information

Date _____

Social Security No. _____

Drivers License No. _____

FEES ARE PAYABLE WHEN SERVICES ARE RENDERED, UNLESS OTHER ARRANGEMENTS ARE MADE AHEAD OF TIME. WE ARE REQUIRED TO MAINTAIN X-RAYS AS PROPERTY OF THIS OFFICE.

Full Name _____ Nickname_____

Address_____ City_____ State_____ Zip_____

Home #_____Cell #_____ Employer_____ Work #_____

Sex : M F Race: African American Caucasian Hispanic Other: _____

Marital Status: S M D W Height_____ Weight_____ Age_____ Birthdate____/____/____

Email Address_____

How did you hear about our clinic?_____

Emergency Contact Name _____ Phone _____

Spouse's Name_____ Spouse's Birthdate_____/_____/_____

Present Complaint

Reason for care (briefly describe symptoms): _____

_____

_____

What is your current pain level? (best) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Is this the result of an accident or injury? □Yes / □No Date of accident: _____

Doctors seen for this condition:_____Treatment rendered_____

Are you currently taking any medications? □Yes / □No What kind? _____

_____

Have you been to a chiropractor before? □Yes / □No Who? _____

List Physicians seen within the last year and for what specific condition(s):

_____ _____

_____ _____

Are you pregnant? □Yes / □No Date of last menstrual period_____

Please list recent vaccinations and date:_____

Health History

Have you ever suffered from any of the following conditions, disorders, or disesases:

Thyroid	□Yes / □No	Diabetes	□Yes / □No	Kidney	□Yes / □No
Asthma	□Yes / □No	Emphysema	□Yes / □No	Other Respiratory	□Yes / □No
High Blood Pressure	□Yes / □No	Heart Disease	□Yes / □No	Heart Attack	□Yes / □No
Other Cardiovascular	□Yes / □No	Stroke	□Yes / □No	Anxiety/Depression	□Yes / □No
Blood/Lymph	□Yes / □No	Ear/Nose/Throat	□Yes / □No	Aids/HIV	□Yes / □No
Neurological	□Yes / □No	Arthritis	□Yes / □No	Multiple Sclerosis	□Yes / □No
Tuberculosis	□Yes / □No	Headaches	□Yes / □No	Eye Problems	□Yes / □No
Dizziness	□Yes / □No	Hepatitis B/C	□Yes / □No	Cancer	□Yes / □No
Eczema	□Yes / □No	Skin Disorders	□Yes / □No	Gastrointestinal	□Yes / □No
Backache	□Yes / □No	Arm Pain	□Yes / □No	Leg Pain	□Yes / □No

Allergies (Please List) □Yes / □No _____

Surgical History(include dates):_____

_ _____

Significant accidents/injuries: _____

Current implants (pacemaker,screws,plates,arteries,IUD,metallic joints, etc.)_____

_____

Do you smoke and how much?_____Do you use alcohol and how much?_____

Father: Living/Deceased(from what?)_____ Mother: Living/Deceased(from what?)_____

Children/Age_____ Hobbies:_____

Goals for Care

- □ Decrease my pain
- □ Improve range of motion
- □ Decrease over the counter and/or prescription medication use for current pain
- □ Perform normal work at home and/or outside the home
- □ Improve enjoyment of life
- □ Perform simple tasks easier and/or with less pain
- □ Improve leisure activities such as exercise or hobbies
- □ Improve my sleep pattern
- □ What activities are you unable to perform since your problem started:_____

Insurance Information

Relationship to insured: Spouse Child Other:_____

If insured is **someone other than self**, please complete information listed below.

Insured's Full Name _____ Insured's Date of Birth _____/_____/_____

Soc. Sec.# _____Employed by _____