Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Today's Date:___________________

Name:____

Date of Birth:__________________

Address:____ City:_________________________

State:_________________ Zip:__________________

Home Phone:________________Work Phone:________________Cell Phone:_________________

E-mail Address:____

Social Security #:____________________________ Age: _______ ❑ Male ❑ Female

Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Other _________________

Emergency contact:__________________Relationship:____________ Phone:________________

Primary Care Physician:____________________________________ Phone:________________

Your Occupation____________________________ Your Employer:________________________

Referred to this Office by: ❑Friend/Family Member - Name?_____________________________

❑Yellow Pages ❑ Mail ❑Clinic Location ❑Other________________

Payment for Services will be by: ❑Self Pay/Cash/Check/Credit Card ❑Health Insurance

❑Automobile Insurance ❑Worker's Compensation

Name of Insurance Co.:_____________________________Insured's Employer: _______________

Insured's SS #:____________ Employer's Phone #:____________Date of Birth:_______________

Are you covered by more than one insurance company? ❑Yes ❑No Name __________________

<u>MEDICAL/FAMILY HISTORY</u> **S** = Self **M** = Mother **F** = Father

(Please indicate which conditions have <u>ever</u> been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	venereal disease

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition_________________________________ Date of Last Physical Exam__________

SURGICAL HISTORY:

1.____ Date:_______________

2.____ Date:_______________

3.____ Date:_______________

Previous Chiropractic Care:____

Have you ever had a metal implant? ❑Yes ❑No Ever been gunshot? ❑Yes ❑No

ACCIDENT HISTORY ❑Job ❑Auto ❑Other 1. ______________________________Date:_______________

❑Job ❑Auto ❑Other 2.______________________________Date:_______________

❑Job ❑Auto ❑Other 3.______________________________Date:_______________

(over please)

NAME:____

What is your race? (Please circle one) White Black or African American Asian American Indian Alaska Native Native Hawaiian or Other Pacific Islander Other Race More Than One Race
What is your ethnicity? (Please circle one) Hispanic or Latino Not Hispanic or Latino

What is your preferred language? English Spanish French German Italian Russian Portuguese Chinese Japanese Korean Vietnamese Other:__________________

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your symptoms (1-10, with 1 being least and 10 being most serious)

1.______________________________________ ____

2.______________________________________ ____

3.______________________________________ ____

4.______________________________________ ____

HOW DID YOUR SYMPTOMS START? ______________________________________
____

SYMPTOMS ARE WORSE IN: ❑MORNING ❑AFTERNOON ❑NIGHT ____________________
SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT ❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET DATE SYMPTOMS BEGAN :________________
SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT ____________________
HAVE YOU EVER HAD THIS BEFORE?: ❑NO ❑YES WHEN?____________________
NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S): ____________
____
____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ❑NO ❑YES Please list:____________________
____
LIST OTHER ALLERGIES:______________________________________
ARE YOU TAKING ANY MEDICATIONS? ❑NO ❑YES PLEASE LIST:____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

ARE YOU PREGNANT? ❑NO ❑YES DATE OF LAST MENSTRUAL PERIOD: ____________________
WHAT IS YOUR SMOKING STATUS? (Please circle one) Current Every Day Smoker Current Some Day Smoker Former Smoker Never Smoked

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:
❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD
❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:
❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:
❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss /confusion
❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever
❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste
❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms
❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

What is your preferred method of communication for private health data? (Please circle one) Home Phone Work Phone Mobile Phone E-mail Standard Mail

Patient's Signature:____________________ **Date**:____________________