About The Patient

Name_____ Date_____ Birth Date_____
Age_____ Gender ☐ M ☐F Marital Status: ☐M ☐S ☐W ☐D Number of Children _____
Address_____ City_____ State_____ Zip_____
Home Phone _____ Cell Phone _____ Work Phone_____
Email _____Occupation_____Employer_____
Significant Other's Name_____ Have you been to a Chiropractor before? ☐Yes ☐No
How did you hear about us? ☐Phonebook ☐Internet ☐Newspaper ☐Drive By
☐Other_____ ☐ Patient _____☐Physician_____

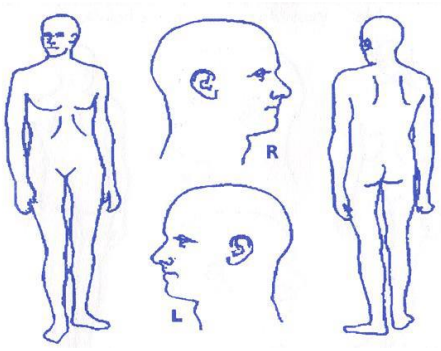
- I authorize the doctor or his staff to render care as deemed appropriate for me and/or my child.
- I authorize the release of any medical or other information needed to process my insurance claim.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits to the provider for services rendered.
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- Person responsible for this account if other than the patient?_____

_____ _____
Patient/Parent Signature (This represents a long term authorization for all occasions of service) Date

Reason For Seeking Care

What is your major symptom/problem
1._____ **When did it start?**_____
Is it: ☐Dull ☐Sharp ☐Numb/Tingle ☐Stabbing ☐Constant ☐Occasional ☐Staying the same ☐Worsening
☐Mild ☐Moderate ☐Severe ☐Worse in the morning ☐Worse in the evening ☐Pain radiates to_____
What makes your condition better?_____
What makes your condition worse?_____
Does your condition affect: ☐Sleep ☐Work ☐Daily Routine ☐Sitting ☐Driving
Who have you seen for this condition?_____
_____
Type of Treatment: _____
_____
Results:_____
_____
NOTES:_____
_____
_____
_____
_____

Please mark ALL areas of concern



Past History

List any past injuries: _____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____
List any hospitalizations and surgeries: _____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____

Family History

☐ Heart Disease ☐ Cancer ☐ Diabetes ☐Autoimmune Disease ☐ Arthritis ☐ Degenerative Disc Disease
☐ Osteoporosis ☐ Genetic Disorders ☐ Other _____

General Health History

Past	Present	Past	Present
☐	☐ Headaches	☐	☐ Urinary Problems
☐	☐ Migraines	☐	☐ Easy Bruising
☐	☐ Shortness of breath	☐	☐ Tobacco Use
☐	☐ Allergies / Asthma	☐	☐ Alcohol Use
☐	☐ Medication side effects	☐	☐ Fibromyalgia
☐	☐ Diabetes	☐	☐ Blood thinner use
☐	☐ Arthritis	☐	☐ Cancer
☐	☐ Earache	☐	☐ Herniated/bulging disc
☐	☐ Blood Pressure ___High or ___ Low	☐	☐ Osteoporosis
☐	☐ Pace maker	☐	☐ Pinched Nerve
☐	☐ Prostate problems	☐	☐ Rheumatoid arthritis
☐	☐ Stroke history	☐	☐ HIV/AIDS
☐	☐ Vision problems	☐	☐ Chest pains
☐	☐ Dizziness	☐	☐ Backaches
☐	☐ Numbness	☐	☐ Sciatica
☐	☐ TMJ	☐	☐ Depression
☐	☐ Fainting	☐	☐ Chronic Fatigue
☐	☐ Other _____		

List any medications you are taking: _____

_____

List any supplement/vitamins you are taking: _____

_____

Has any doctor or other professional advised you to "Go to a Chiropractor" ☐No ☐Yes **Name:** _____

_____

Accidental Injuries

Date of Accident: _____ **Time:** _____**AM** _____ **PM** **Location:**_____
How did the accident occur? ☐ Auto Collision ☐ On the job injury ☐ Other: _____
Did you report the injury to your supervisor/employer? ☐ Yes ☐ No
Did they recommend care at our office? ☐ Yes ☐No

Auto Collision:
Were you: ☐ Driver ☐ Passenger ☐ Pedestrian
Were you struck from: ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐Parked
Did your vehicle roll: ☐ Yes ☐ No **Did air bags deploy** ☐ Yes ☐ No
Were traffic citations issued to you or your driver: ☐ Yes ☐No **To other drivers involved:** ☐Yes ☐ No
Did you require hospitalization? ☐ Yes ☐ No

Check symptoms you have noticed since the accident:
☐Headaches ☐Neck Pain ☐Neck Stiffness ☐Sleeping Problems ☐Back Pain ☐Nervousness ☐Tension
☐Chest Pain ☐Dizziness ☐Pin/needles in Arms ☐Pin/needles in Legs ☐Fatigue ☐Ears Ringing ☐Weakness
☐Cold Sweats ☐Lightheadedness ☐Other:_____

How many days of work have you missed? _____ **Dates:** _____
Your Auto Insurance Company: _____
Other Insurance Companies involved: _____
Have you been contacted by an insurance company regarding this claim? ☐Yes ☐No
Do you have an attorney that has advised you in this case? ☐Yes ☐No
If Yes,: Name_____ **Phone #:**_____