Doctors & Therapist from Multiple Working Together for Every Patient.

PATIENT INFORMATION FORM

Date: ___________________ Patient # ______________

First Name: ________________________________ Last Name: ____________________________________

Date of Birth: ______________________ Age: ____________ Gender: ☐Male ☐Female

Social Security Number: ______________________________

Address: ____

City: ___________________ State: ____________________________ Zip: _________________________

Email Address: ____

Home Phone: _______________________________ Cell Phone: _________________________________

Insurance Carrier: ____

Policy Number: ____

Name of Subscriber: ______________________________ Date of Birth: ___________________________

Subscriber's Social Security Number: _______________________________

Relationship to Patient: ☐Self ☐ Spouse ☐ Parent

Are any of these problems related to: ☐Work Injury ☐ Auto Accident ☐Other: __________________

Who is your Primary Care Provider?

Name: ____ Phone: _____________________________

Occupation: _______________________________ Employer: ___________________________________

Emergency Contact and Phone Number: ____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Spouses Name: ____

Child's Name and Age: ____

Child's Name and Age: ____

Child's Name and Age: ____

Child's Name and Age: ____

How were you referred to our office? ____

Have you consulted a chiropractic before? ☐Yes ☐No When? ___________________

Signature: ____ Date: _________________________

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Current Health Problems: (What is prompting you to seek our services?)

____

____

____

1. When did you first notice your current symptoms? ____________

2. How often do your symptoms occur? ☐Constantly ☐Intermittently

3. Rate your pain on the scale below.

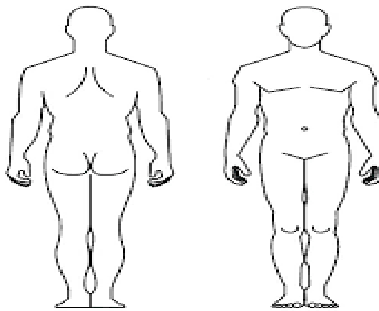
4. Quality of symptoms:
(What does it feel like? Check all that apply)

☐*Numbness* ☐*Tingling*
☐*Dull* ☐*Stiffness*
☐*Aching* ☐*Cramps*
☐*Nagging* ☐*Sharp*
☐*Burning* ☐*Shooting*
☐*Throbbing* ☐*Stabbing*

Other:______________________________

____

5. Where does it hurt?
Mark the area(s) on the illustration below.
"O" for current pain "X" for previous pain



6. Does the pain radiate (shoot) to other areas of your body? ☐Yes ☐No

7. What makes the pain better or worse? (Time of day, movement, certain activities, etc.)

____

____

8. Prior Interventions: (What have you done to relieve the symptoms?

☐*Prescription medication* ☐*Over-the-counter drugs* ☐*Homeopathic remedies*
☐*Physical therapy* ☐*Surgery* ☐*Acupuncture* ☐*Chiropractic*
☐*Massage* ☐*Ice* ☐*Heat*

9. Does your current condition interfere with your:

Work or Career:	☐*Yes*	☐*No*
Recreational activities:	☐*Yes*	☐*No*
Household responsibilities:	☐*Yes*	☐*No*
Personal relationships:	☐*Yes*	☐*No*

For Office Use Only
Patient Name:
Date of Birth:
Consultation Notes:
Provider Initial: ____________

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For Office Use Only:
Patient Name: ____________
Date of Birth: ____________

10. Review of Systems.

Our care focuses on the integrity of your nervous system, which control and regulates your entire body. Please mark any condition that you've **Had** or currently **Have.**

a. Musculoskeletal

Had	Have	
☐	☐	Osteoporosis
☐	☐	Arthritis
☐	☐	Foot/ankle pain
☐	☐	Knee injuries
☐	☐	Hip disorders
☐	☐	Shoulder problems
☐	☐	Neck pain
☐	☐	Elbow/wrist pain
☐	☐	Back problems
☐	☐	TMJ issues
☐	☐	Scoliosis

b. Neurological & Cardiovascular

Had	Have	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Headache
☐	☐	Dizziness
☐	☐	Excessive Bruising
☐	☐	Numbness
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Poor circulation

c. Respiratory & Digestive

Had	Have	
☐	☐	Asthma
☐	☐	Digestive issues
☐	☐	Shortness of breath

d. Sensory, Integumentary, Endocrine

Had	Have	
☐	☐	Blurred vision
☐	☐	Ringing in Ears
☐	☐	Hearing loss
☐	☐	Thyroid issues
☐	☐	Immune disorders

e. Constitutional

Had	Have	
☐	☐	Fainting
☐	☐	Fatigue
☐	☐	Sudden weight gain/loss
☐	☐	Weakness

11. Past Personal, Family and Social History

Please identify your past health, including accidents, injuries, illnesses and treatments.

a. Illnesses

- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Stroke
- ☐ Epilepsy

Other: ____________________________

b. *Operations*

- ☐ Pacemaker
- ☐ Heart Surgery
- ☐ Hysterectomy
- ☐ Elective Surgery: __________
- ☐ Spine ____________________

Other ________________________________

c. *Treatments*

Past	Current	
☐	☐	Chiropractic care
☐	☐	Massage Therapy
☐	☐	Physical Therapy
☐	☐	Acupuncture
☐	☐	PRP (Platelet Rich Plasma)
☐	☐	Medications/supplements

d. Family History

Are there any hereditary health issues/diseases that we need to know about? ____

e. Social History

"0" No stress "5" great deal of stress

Daily Stress **0-----1-----2-----3-----4-----5**

"0" Not healthy "5" Very healthy

Rate your healthy lifestyle **0-----1-----2-----3-----4-----5**
(Ex: water, food, caffeine, alcohol intake; etc.)

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Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials

______ **I instruct the provider to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health.**

______ **I acknowledge and may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

______ **I realized that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.**

______ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

______ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I received.**

______ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.**

______ **I acknowledge that a 24-hour cancellation notice is required. Without proper notification a missed appointment may result in a $50 cancellation fee.**

If the patient is a minor child, print child's full name: ______________________

Signature: ______________________ Date (MM/DD/YYYY): ______________________

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