



PATIENT INFORMATION-1

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Name _____ S. S. #: _____
Address _____ City _____ State _____ Zip _____
Phone _____ Fax _____ Age _____ Birth Date _____
Sex: Male Female Married Single Widow Divorced
Employer _____ No. of Children _____ Ages _____
Address _____ Name / Number to contact for emergency _____
City, State, Zip _____
Work phone _____
Spouse's name _____ Email _____

Billing Information

Applicable Insurance / Responsible Party Self Spouse Auto Ins. Workers' Comp Health Insurance
Insurance Co. _____ Deductible _____ Co-Pay _____
Address _____ Policy No _____
Address _____ Claim No _____
City / State / Zip _____ Contact Person _____
Insured name _____ Phone _____ Fax _____

Attorney name _____
Address / City / State / Zip _____
Phone number _____

Health / Medical History

List any surgeries or hospitalizations _____

List previous trauma including fractures, motor vehicle accidents, strains / sprains _____

Are you at present under a medical doctor's care? Yes No
If yes, explain and give name and city of doctor _____

List all medications you currently are taking and why _____

List drug allergy or sensitivity _____

Have you had any of the following? X-Rays EMG MRI EEG Myelogram Cat Scan Bone Scan EKG

CLINIC USE ONLY

Height _____ Weight _____
Pulse: Left _____ Right _____
Blood Pressure Left _____ Right _____

All co-pay's due must be paid at time of services are rendered.



PATIENT INFORMATION-2

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Complaint or Injury History

Date of Injury _____

Automobile Work related Motorcycle Bus Bicycle Slip and fall Other _____

Briefly describe your injury or complaint, date first noticed pain _____

Have you ever had this problem or similar condition in the past? Yes No

Are you presently under a doctor's care for this injury/complaint? Yes No

If yes to either of the above, explain _____

Have you ever been under a Chiropractor's care before for this or any other condition? Yes No

If yes, explain and give name and city of doctor and dates _____

Where is your pain located?

Low back Mid back Upper back Neck Chest Abdomen Groin Left buttock Right buttock

Left thigh Right thigh Left calf Right calf Left ankle/foot Right ankle/foot Left shoulder

Right shoulder Left arm Right arm Left hand/wrist Right hand/wrist Head Face

Other _____

Please check the words below that best describe your pain.

Burning Sharp Aching Throbbing Shooting Other _____

What time of day is your pain at its worst?

Morning upon rising Later in the morning Afternoon Evening Bedtime Night (during sleep hrs)

Pain is always the same Pain varies, but is not worse at any particular time

Do you have any of the following?

Numbness Tingling Weakness Dizziness Coldness Increased sweating Muscle spasm

Loss of balance Skin discoloration Bowel problems Bladder problems Blurred vision

What makes your pain worse?

Coughing Sneezing Sitting Standing Lying down Walking on level Waking, incline / decline

Bending forward Bending backward Physical activity Sexual activity Other _____

What makes your pain better?

Relaxation Sitting Standing Lying down Heat Ice Medicine Walking Bio-feedback TENS

Acupuncture Chiropractic treatment Osteopathic manipulation Bed rest Traction Physiotherapy



PATIENT INFORMATION-3

Have you had any of the following?

- Abnormal bleeding
- Allergies
- Anemia
- Appendicitis
- Arteriosclerosis
- Arthritis
- Asthma
- Cancer
- Chemotherapy
- Cough (unexplained)
- Dentures
- Diabetes
- Eczema
- Emphysema
- Epilepsy or Seizures
- Glaucoma
- Gout
- Headaches
- Heart attack
- Heart disease
- Heart valve disease
- Hemophilia
- Hiatal hernia
- High blood pressure
- Intestinal disease
- Kidney disease
- Low blood pressure
- Pacemaker
- Polio
- Prior injury
- Prosthesis
- Rheumatic fever
- Smoker
- Stroke
- Thyroid disease
- Tuberculosis
- Ulcers
- Venereal disease
- Other _____

Motor Vehicle Accident

Were you? Driver Passenger Restrained (lap only shoulder / lap)

If passenger Front Right rear Left rear

Did you strike another vehicle? Yes No

Were you struck by another vehicle? Yes No

Impact from? Left Right Front Rear

Were you? Stopped Moving Slowing

Did you lose consciousness? Yes, how long? _____ No

Were you braced for impact? Yes No

Upon impact did you strike? Steering wheel Dashboard Windshield Door Side window headrest
 Other _____

If you went to the hospital, when? Time of accident Later that day Next day Other _____

Name and address of hospital _____

If you went to the hospital, how were you transported? _____

If you went to the hospital, were you x-rayed? Yes No

Work Related Accident

Reported injury/s to employer? Yes No

Were you? Lifting Pushing Pulling _____ lbs.

Were you wearing a brace? Yes No

Disability? Total Partial Restricted duties

Lost time from work? Yes No

If yes, give dates: From _____ to _____

I UNDERSTAND AND AGREE that (regardless of my insurance status) I am ultimately responsible for the balance of my accounts for any professional services rendered. I have read all the information on these sheets and have completed the questionnaire. I certify this information is true and correct to the best of my knowledge. I will notify you on any changes in my health insurance status or any change on the above information.

Signature of patient

Date

Signature of parent of minor

Date