Confidential Patient Information

Date_____

Name_____Phone_____cell_____

Address_____City_____ Zip_____

Date of Birth ____/____/_____ Age_____ Sex_____ SSN_____

Email address_____

Marital Status: **S M D W DP** Name of Spouse_____

Number of Children_____ Number being treated in this office_____

Referred by_____

Emergency Contact _____Phone _____

Your Occupation_____ Employer _____

Have you received Chiropractic Care before? _____ Where? _____

What technique was used? _____ What are your treatment goals:

a) short term_____ b) long term _____

Is this appointment the result of an injury sustained while on the job? **Y N**

Is this appointment the result of an auto accident? **Y N**

Are you currently working? **Y N**

Have you ever had the same or similar condition? **Y N**

If yes, when?_____ Describe_____

Female: Are you pregnant? **Y N**

Have you ever suffered from:

Dizziness_____	Tuberculosis _____	Asthma _____	Sinus Trouble _____
Backaches_____	Arthritis _____	Neuritis _____	Anemia _____
Heart Trouble _____	Headaches _____	Digestive Disorders ___	Rheumatic Fever ____
Diabetes _____	Numbness _____	Nervousness _____	Cancer _____

Date of last Physical Examination_____

What operations have you had? _____ Dates _____

Serious Illness? _____ Dates _____

Please describe the principle health concern for which you made this appointment:

_____

Are there other conditions you are interested in correcting?

_____

What is your pain level RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

(no pain) (unbearable pain)

What is your TYPICAL/AVERAGE pain level?

0 1 2 3 4 5 6 7 8 9 10

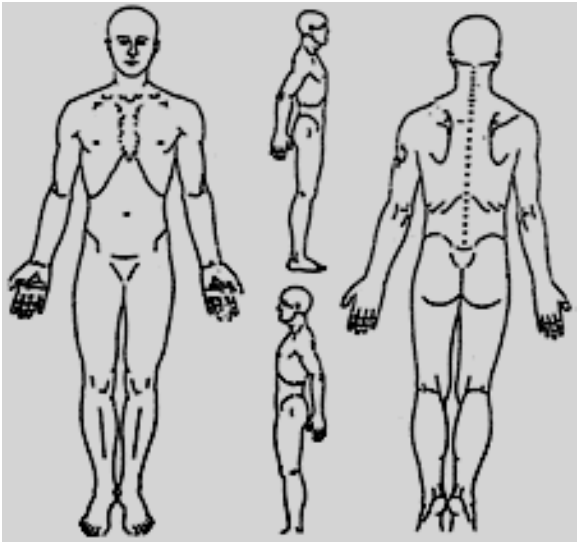
(no pain) (unbearable pain)

What is your pain when it is AT ITS WORST?

0 1 2 3 4 5 6 7 8 9 10

(no pain) (unbearable pain)

Please mark location(s) of pain by circling the area:



What aggravates the condition? _____

Is condition progressively worsening? **Y N** Constant _____ Comes & goes_____

Is condition interfering with (circle): Work Sleep Daily Activities Other_____

How long has it been since you felt really good?_____

What do you believe is wrong with you? _____

Other doctors seen for this condition: _____

Doctor contact info _____

Have you been treated for other health conditions by a physician in the last year? **Y N**

Describe _____

What Medications/drugs are you taking? _____

Do you take supplements? _____

Are you wearing (circle): Heel lifts Sole lifts Arch supports

PAYMENT IS EXPECTED AT THE TIME OF VISIT

Name of person responsible for payment: _____

To the best of my knowledge, the above information is complete and accurate. I authorize and request chiropractic services for myself or my minor child, so designated above, and give my consent to any advisable diagnostic and treatment procedures to be administered by the attending chiropractor.

I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand and agree that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature _____ Date_____

Guardian or spouse's signature authorizing care _____ Date _____