PATIENT INFORMATION

File # ______________ Date ______________

Patient Information

Thank you for choosing our practice for your Chiropractic needs. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. If you have any questions or concerns, please ask for assistance. We will be happy to help you. Thank You.

Name ______________________________ Date of Birth ______________

Home Phone ______________ Cell Phone ______________ Sex: ☐ Female ☐ Male

Address ______________________ City ______________ State _____ Zip ________

E-mail Address ______________________________ Primary Language ___________

Are you: ☐ Minor ☐ Single ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Separated ☐ Widow

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic

☐ Native Hawaiian or Other Pacific Islander ☐ White

Your Occupation ____________________ Your Employer ______________________

Business Address ______________________________ Work Phone ______________

Spouse or Parent Name __________________ Workplace __________ Work Phone ________

Name of person responsible for this account? ______________________________

Address ______________________ City ______________ State _____ Zip ________

Emergency Contact ________________ Phone ____________ Relationship __________

Whom may we thank for referring you to us? ______________________________

Insurance Information - Please provide us with your insurance card so we can make a copy.

Is this visit related to an accident?

Automobile ☐ Yes ☐ No Work Related ☐ Yes ☐ No Other ☐ Yes ☐ No

Date of injury ____________ Time ____________ Place ____________________

Insurance Company ____

Claim # ____________________ Adjuster Phone # ______________________

Health History

Health Conditions: (i.e. high blood pressure, high cholesterol, diabetes, thyroid) Please list type and year:____

____

Accidents / Injuries: Please list type and year ____________________________

____

____

Hospitalization / Surgeries: Please list type and year________________________

____

Do you have a pacemaker?	Yes	No	____________
Have you ever had cancer?	Yes	No	____________
Are you losing weight now without trying?	Yes	No	____________
Are you coughing up blood or noticing it in your stools or urine?	Yes	No	____________
Have you had any loss of bladder or bowel control?	Yes	No	____________
Have you lost consciousness or had double vision recently?	Yes	No	____________

Have you had any recent episodes of weakness? Yes No ____________

Have you had any recent dental work? Yes No ____________

Do you have any other symptoms or health problems? Yes No ____________

FEMALES ONLY

Is there any chance that you are pregnant now? Yes No ____________

Date of last menstrual cycle ____________ How many children? ___ Vaginal birth ___ C-section ___

Pregnancy complications? Yes No ____________

Have you had a bone density scan? Yes No Month _______ Year_______

Are you currently taking any medications? ☐ Yes ☐ No If yes, please continue.

Medications / prescribed and over the counter: Please allow us to make a copy of the list you carry with you.

____________ Dosage ____________ Frequency ________

____________ Dosage ____________ Frequency ________

____________ Dosage ____________ Frequency ________

What vitamins or other nutritional supplements do you currently take?

____________ Dosage ____________ Frequency ________

____________ Dosage ____________ Frequency ________

____________ Dosage ____________ Frequency ________

Do you have any medication allergies? ☐ Yes ☐ No ____________

Family Health History

List immediate family members that have these issues: M = mother P = father B = brother S = sister

MGM = maternal grandmother / MGF = maternal grandfather

PGM = paternal grandmother / PGF = paternal grandfather

Cancer Yes/No What kind?____________

____

High blood pressure ____________ Diabetes Yes/No Type 1 (Insulin Dependent) Type 2

Heart Disease Yes No What kind? ____________ Stroke ____________

Fibromyalgia ____________ Rheumatoid Arthritis ____________

High cholesterol ____________ Thyroid Yes/No What problems?____________

Osteoporosis ____________ Mental Illness ____________

Other ____________

Wellness

Name of local primary physician ____________ Specialists ____________

Tobacco use: Never Smoked Live with a smoker

Current every day tobacco use, ________ packs per day. Current occasional tobacco use,

________ per week. What Type Cigarettes Chewing Tobacco Cigars

Former tobacco user / Quit Date ____________ How long did you use? ____________ years

Alcohol consumption: None Rarely Social Drinker Recovering Alcoholic

Beer ________ a day Mixed Drinks ________ a day Wine ________ a day