Personal Information & Demographics

Date: ___________________

Name ____

Address ________________________________ City/ST/Zip _____________________________________

Age _______ Date of Birth ___/_____/_______ Marital Status ________________

E-mail Address ____

Home No. _____________________ Cell No._____________________ Contact Preference_________

- Social Security & Drivers license are needed - if we file insurance claims for you.

Social Security ________________________________

Driver's License No. _______________________________________ Exp. Date ____________________

Occupation _______________________________________

Emergency Contact Name ______________________________ Tel. No _______________________________

How did you hear about us? ____

Is the condition we are treating related to an auto accident? Yes ______ No ______

Is the condition we are treating related to another type of accident? Yes ______ No ______

- We utilize a text reminding service, for appointments. Appointments however are [your] responsibility!
- Knowing your insurance benefits, is [your] responsibility.

Insured or Authorize Person Signature: I authorize payment of medical benefits for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services even those covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed ____ Date ________________________

PATIENT HISTORY

Last Name ________________________________ First Name _______________________________

Date of Birth____________________ Social Security Number _________-______-_________

Your Occupation _________________________________

Have you ever been to another doctor for this problem? Y / N Who? ______________________

Have you been to a chiropractor in the last 3 years? Y / N

Who referred you to this office? ______________________________

WHAT BRINGS YOU TO OUR OFFICE?

PRIMARY COMPLAINT: ____

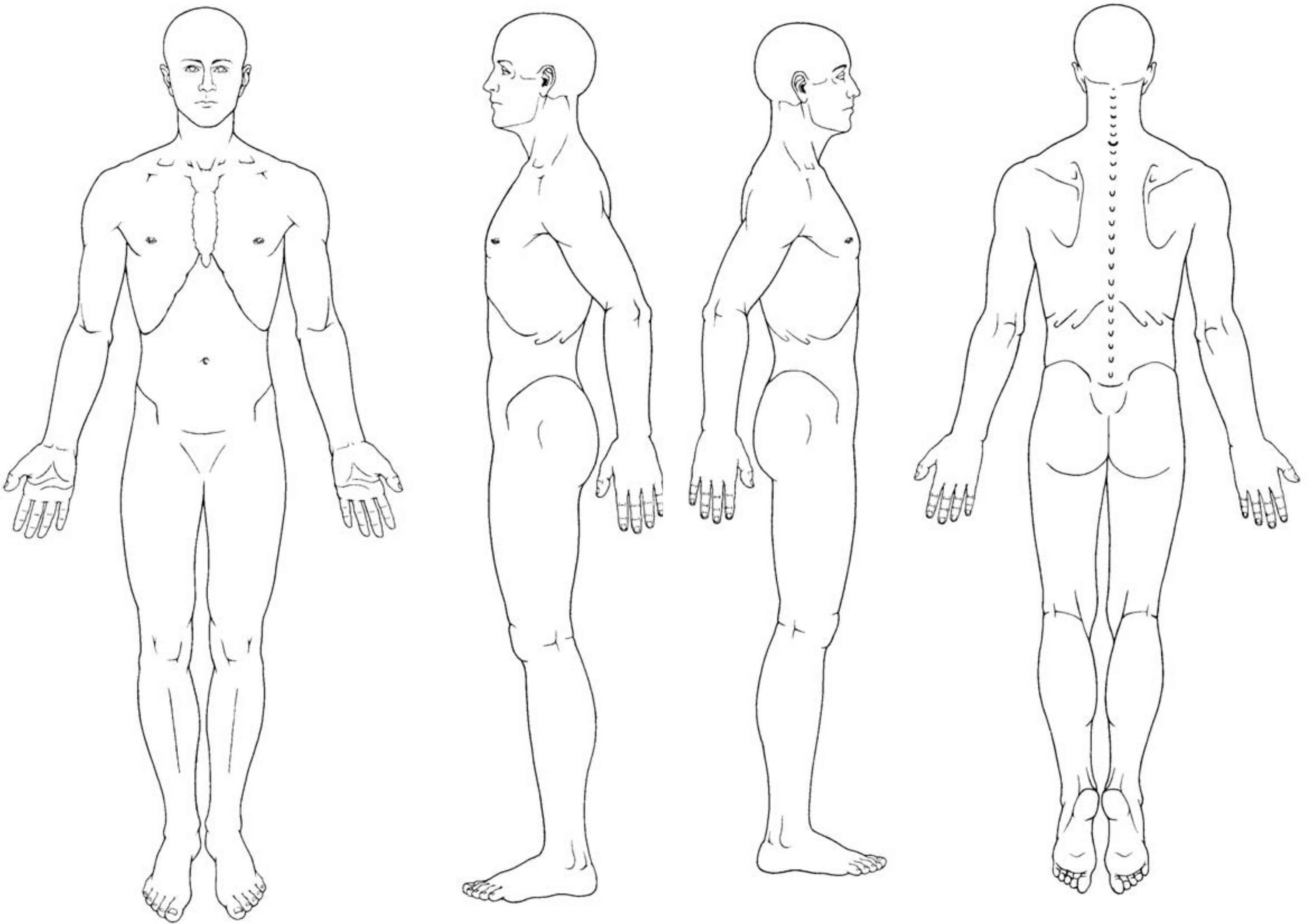
- Date when symptom first appeared _____________________________
- Did it begin _____ Gradual _____ Sudden _____ Progressive over time
- What makes the symptoms increase? ____
- What relieves the symptoms? ____
- Type of Pain _____ Sharp _____ Dull _____Ache _____ Burn _____Throb
- Does the Pain Radiate anywhere? Y / N _____ Arm _____ Leg _____ Head
- Do you experience Numbness or Tingling? _____Y _____N
- How often do you experience these symptoms?
  _____Daily _____1-2 x Week _____1-2 x Month _____Constant _____Other
- PAIN INTENSITY: Circle the intensity of your pain, on a scale 1-10… 10 being the worst.
  1 2 3 4 5 6 7 8 9 10

OTHER COMPLAINT: ____

- Date when symptom first appeared _____________________________
- Did it begin _____ Gradual _____ Sudden _____ Progressive over time
- What makes the symptoms increase? ____
- What relieves the symptoms? ____
- Type of Pain _____ Sharp _____ Dull _____Ache _____ Burn _____Throb
- Does the Pain Radiate anywhere? Y / N _____ Arm _____ Leg _____ Head
- Do you experience Numbness or Tingling? _____Y _____N
- How often do you experience these symptoms?
  _____Daily _____1-2 x Week _____1-2 x Month _____Constant _____ Other
- PAIN INTENSITY: Circle the intensity of your pain, on a scale 1-10… 10 being the worst.
  1 2 3 4 5 6 7 8 9 10

PATIENT SIGNATURE ____DATE _____________________

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above.

Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	Where you experience Pain
NNN	Where you experience Numbness
TTT	Where you experience Tingling
BBB	Where you experience Burning
CCC	Where you experience Cramp/Tension

PATIENT SIGNATURE ______________________________________DATE ____________________

Patient History

Please list all previous treatments for this condition:

Name of Treating Physician ______________________________ Dates of Treatment __________
Type of Treatment or Drugs Prescribed ____

Name of Treating Physician ______________________________ Dates of Treatment __________
Type of Treatment or Drugs Prescribed ____

Please list all past surgeries:

Type ___________________________ When ______________ Doctor __________________
Type ___________________________ When ______________ Doctor __________________
Type ___________________________ When ______________ Doctor __________________
Type When Doctor

Please list all previous auto accidents, accidents and falls (even if sought NO treatments for it) **:**
What ____ When ____________________
What ____ When ____________________
What ____ When ____________________
What ____ When ____________________

Please list any medications or vitamins you are currently taking:
____
____
____

Other problem areas: check off… or make 'yes' or 'no'

Insomnia	Any Immune Problems? Y / N
Fatigue	Any Eye, Ear, Nose, or Throat? Y / N
Stress	Any Heart Problems? Y / N
TMJ	Any Lung Problems? Y / N
Shoulder Problems	Any Breast Problems? Y / N
Elbow / Elbow pain	Any Urinary Problems? Y / N
Leg Problems	Any Thyroid or Diabetes? Y / N
Knee Problems	Any Mental – Emotional issues? Y / N
Foot Problems	Any Allergies? Any Asthma? Y / N
Disc Problems	List other conditions you think are relevant:___________
Arthritis	____
Scoliosis	____

PATIENT SIGNATURE ______________________________________DATE ____________________