



CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:		Date:	
Address:			
Street	City	State	Zip
Home phone:		Work phone:	
Cell phone:		Email address:	
Best time/place to contact you:			
Date of birth:		Age:	
No. of children:		Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Height:		Weight:	
Driver's license number:		SSN:	
Marital status: M S W D		Spouse/guardian name:	
Occupation:			
Employer's name & address:			
Spouse's Occupation/Employer:			
Name of person responsible for account:			
Do you have insurance that covers Chiropractic care? Yes <input type="checkbox"/> No <input type="checkbox"/>		Do you have Medicare coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Name of Insurance Company:			
Insurance Policy number:		Insurance Company phone number:	
Insurance Company address:			

Who may we thank for referring you? _____

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General Health History".

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	<input type="checkbox"/>
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	<input type="checkbox"/>
Medical Doctor	<input type="checkbox"/>
Dentist	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)

- a. _____
- b. _____
- c. _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)

- a. _____
- b. _____
- c. _____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

- a. _____
- b. _____
- c. _____

Why are you here at this point in time?

I consent to a professional & complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____

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