

Patient Information

Welcome, We are pleased to welcome you to our practice. Please take the time to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you to maintain your health.

Name _____ Soc. Security # _____
Last First name M. Initial

Address _____

City _____ State _____ Zip _____ Phone _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient employed by _____ Occupation _____

Business address _____ Business phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ home phone _____ work _____

Insurance Information

Insurance company _____

Person Responsible for account _____

**Fill out next section if party responsible is not the patient or the insurance holder is not the patient

Relationship to patient _____ date of birth _____

Soc. Security # _____ phone number _____

Address _____ city _____ zip _____

Person responsible employed by _____ business phone _____

Business address _____

Reason for visit

Have you ever seen a chiropractor? yes no If yes, when, why? _____

Your reason for this visit _____

Please describe your current pain and its location _____

When did symptoms begin _____ Have you similar condition in the past? _____

Is pain getting worse better same comes and goes How often do you have this pain? _____

Have you been treated by a medical physician for this condition? _____

If so, when and where? _____

Activities or movements that are difficult /painful to perform: sitting bending lying down lifting

Type of pain: sharp dull throbbing aching burning tingling numbness cramping
 stiffness swelling other _____

Is pain interfering with: work sleep Daily routine work recreation

Health history

Please list any medication , including pain medication, that you are taking _____

Please list any serious injuries or surgeries you have had in the past 10 years:

Falls _____ date _____

Broken bones _____

Dislocations _____

Surgeries _____

Other serious Injuries _____

Women: Are you pregnant? yes no if so how far along? _____ Nursing baby? yes no

Medical conditions

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Frequent neck pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Congenital heart defects | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Wrist pain | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Fainting / seizures | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arm pain | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Numbness. |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Glaucoma | Where? _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lower back problems | <input type="checkbox"/> Artificial | <input type="checkbox"/> Tingling , |
| <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Severe/frequent | bones/joints | where? _____ |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> earaches | <input type="checkbox"/> Cancer | <input type="checkbox"/> Muscles spasm, |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> HIV positive/AIDS | where? _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Anorexia/ Bulimia | |
| <input type="checkbox"/> Allergies | | | |

Personal Habits

	Heavy	moderate	light	none
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third party payers and /or health professionals. I authorize and request my insurance company to pay directly to the chiropractor or the chiropractic group insurance benefits otherwise payable to me. ***I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents and any collection fees, if applicable, on my account.***

X _____

Signature of patient (or parent of minor)

_____ Date

If patient is a minor: I authorize Chiropractic First to administer treatment to my child _____ as the doctor so deems necessary .

parent or legal guardian **X** _____ date _____