WELCOME

PATIENT INFORMATION

Date _____

SS _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____
City _____
State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for ____ years

Occupation _____

Patient Employer/School _____

Employer/ School Address _____

_____

Employer / School Phone _____

Spouse's Name _____
Birthdate _____
SS# _____
Spouse Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (____) _____

Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY , CONTACT
Name _____
Relationship _____
Home Phone (____) _____
Work Phone (____) _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ID # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ID # _____

ASSIGNMENT AND RELEASE
I certify that I, and or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company

Dr. _____ all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized the use of my signature on all insurance submissions.
The above –named doctor may use my health care information and may disclose such information to the above-named Insurance Compay(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for relates services. The consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

O V E R

HEALTH HISTORY

Place a mark on "Yes or "No" to indicate if you have had any of the following:

AIDS/HIV ☐ Yes ☐ No
Alcoholism ☐ Yes ☐ No
Emphysema ☐ Yes ☐ N
Anemia ☐ Yes ☐ No
Fracture ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Bleeding ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No
Chemical Dependency ☐ Yes ☐ No
Chicken Pox ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Migraine ☐ Yes ☐ No
Epilepsy ☐ Yes ☐ No
Mononucleosis ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Goiter ☐ Yes ☐ No
Gonorrhea ☐ Yes ☐ No
Gout ☐ Yes ☐ No
Heart Disease ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
Hernia ☐ Yes ☐ No
Herniated Disk ☐ Yes ☐ No
Herpes ☐ Yes ☐ No
High Cholesterol ☐ Yes ☐ No
Kidney Disease ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
Measles ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Miscarriage ☐ Yes ☐ No
Suicide Attempt ☐ Yes ☐ No
Multiple Sclerosis ☐ Yes ☐ No
Mumps ☐ Yes ☐ No
Osteoporosis ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
Parkinson's Disease ☐ Yes ☐ No
Pinched Nerve ☐ Yes ☐ No
Pneumonia ☐ Yes ☐ No
Polio ☐ Yes ☐ No
Prostate Problem ☐ Yes ☐ No
Prosthesis ☐ Yes ☐ No
Psychiatric Care ☐ Yes ☐ No
Rheumatoid Arthritis ☐ Yes ☐ No
Allergy Shots ☐ Yes ☐ No
Ulcer ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No
Vaginal Infections ☐ Yes ☐ No
Thyroid Problems ☐ Yes ☐ No
Tonsillitis ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Tumors, Growths ☐ Yes ☐ No
Venereal disease ☐ Yes ☐ No

OTHER

Ligament Sprain ☐ Yes ☐ No
Broken Bones ☐ Yes ☐ No
Surgery ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No

PATIENT SUBJECTIVE COMPLAINTS

Complaints (area): Primary_____ Second_____ Third_____

Pain Scale: (*Primary*) no pain 1 2 3 4 5 6 7 8 9 10 worst pain (*Secondary*) 1 2 3 4 5 6 7 8 9 10

Date of Injury / Onset? (Primary Complaint) _____ (Secondary Complaint) _____
Please explain the cause of the injury / problem.

_____

_____

Is the problem getting: Better / Worse
Have you ever had this complaint before this onset? Y / N
If so, when: _____ How many times? ☐ one time ☐ two or more times

Have you been treated by a chiropractor previously Y / N If so, when _____
Have you been treated by a physical therapist previously Y / N If so, when _____

Have you seen any other physicians for your complaint(s)? **Y / N** Who? _____
When? _____

What concerns / issues would prevent you from receiving care in this clinic? (Time Finances Transportation)

ACTIVITY HISTORY

What is your preferred activity / exercises _____

How long have you been training? _____

What are your goals? _____

What are your limitations? _____

What are your strong points? _____

What movements cause pain ? _____

What makes it feel better? _____