

CONFIDENTIAL PATIENT INFORMATION

DATE _____

Name _____ Social Security Home Phone _____

Address _____ City _____ Zip Code _____

Age _____ Birth Date _____ Marital: M S W D How Many Children? _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Name of Husband or Wife _____

Name of Nearest Relative _____ Address _____ Phone _____

Referred by _____

Is the condition due to injury or sickness arising out of employment? _____

Is the condition due to injury or sickness arising out of auto or other accident? _____

Days lost from work? _____ Date symptoms appeared or accident happened _____

Have you ever had the same or a similar condition: Yes _____ No _____ If yes, when and describe _____

Date of last physical examination _____

What operations have you had? _____ When? _____

Serious Illnesses? _____ When? _____

Have you ever suffered from:

- | | | |
|-------------------------|---------------------|--------------------------------|
| 1. Dizziness: _____ | 6. Arthritis: _____ | 11. Digestive Disorders: _____ |
| 2. Backaches: _____ | 7. Headaches: _____ | 12. Nervousness: _____ |
| 3. Heart Trouble: _____ | 8. Numbness: _____ | 13. Sinus Trouble: _____ |
| 4. Diabetes: _____ | 9. Asthma: _____ | 14. Anemia: _____ |
| 5. Tuberculosis: _____ | 10. Neuritis: _____ | 15. Rheumatic Fever: _____ |
| | | 16. Cancer: _____ |

Purpose of this appointment _____

Other doctors seen for this condition _____

Have you been treated for any health condition by a physician in the last year? YES () NO ()

Describe _____

What medications or drugs are you taking? _____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself—not between my insurance company and this office. I request The Chiropractic Clinic to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance company.

If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

HEALTH INSURANCE: YES () NO () COMPANY _____

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

1. What is your major symptom? _____

2. If this is a reoccurrence, when was the first time you noticed this problem? _____

How did it occur? _____

Has it become worse recently? _____ . If yes, when and how? _____

3. How frequent is the condition? _____

How long does it last? _____

4. Are there any other conditions or symptoms you have that may be related to your major symptom? _____

Are there other unrelated health problems? _____

5. If pain is involved, what type is it—sharp, dull, etc.? _____

6. Is there anything you can do which seems to provide relief? _____

7. What things seem to make the problem worse? _____

8. Have you had any broken bones? _____ If yes, please list them and give dates.

9. List any major accidents you have had other than those that might be mentioned above _____

10. To your knowledge, have you had any diseases, major accidents, or injuries not included on this form either in the past or the present? _____ If yes, please explain: _____

11. WOMEN ONLY: Are you pregnant or do you feel there is any possibility you might be pregnant? _____

12. Remarks: _____
