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

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

Personal Habits

	Heavy	moderate	light	none
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Appetite	□	□	□	□

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** _____