

Current Chiropractic Clinic

Patient Data

Date: ___/___/_____

Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _____

First Name _____ Middle Initial _____ Last Name _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip _____

Home Phone (____) _____ - _____

Cell Phone (____) _____ - _____

Work Phone (____) _____ - _____

Email _____

Date of Birth ___/___/_____

Sex: Male Female

Social Security Number: _____ - _____ - _____

Marital Status: Single Married Other _____

Employment Status:

Employed Unemployed FT Student PT Student Other _____

How did you hear of us?

Radio Inrternet Newspaper Friend/Family Other _____

Employer Data

Your Occupation _____ Your Job Description _____

Employer Name _____

Address _____

City _____ State _____ Zip _____

Spouse Data

First Name _____ Middle Initial _____ Last Name _____

Home Phone (____) _____ - _____

Cell Phone (____) _____ - _____

Work Phone (____) _____ - _____

Email _____

Date of Birth ___/___/_____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Home Phone (____) _____ - _____

Cell Phone (____) _____ - _____

Work Phone (____) _____ - _____

Email _____

Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Spouse Auto Insurance
 Worker's Comp Insurance Medicare Medicaid Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Insur. Group # _____

Policy Holder's Date of Birth: ___/___/_____ Primary Care Physician: _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer?

Yes No Date: ___/___/_____ Time: _____am/pm

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____ Date: ___/___/_____

Consent to treat a minor: (Minor's printed name) _____

Guardian / Spouse's Signature authorizing care _____ Date: ___/___/_____

SIGNATURE OF PHYSICIAN: _____ Date: ___/___/_____

Medical Conditions: (Check all that apply to you)

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other: _____ | | | |

Surgeries: (Check all that apply to you)

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical spine | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Prostate | <input type="checkbox"/> Lumbar spine | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Thoracic spine | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Gastro-intestinal | <input type="checkbox"/> Uro-genital | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Other: _____ | | | |

Allergies: (Check all that apply to you)

- | | | | |
|-------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish and Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanuts |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Wheat/Glutens | <input type="checkbox"/> Other _____ |

Social History: (Check all that apply to you)

- | | | | |
|------------------|--------------------------------------|--------------------------------------|--------------------------------|
| Caffeine use: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Drink Alcohol: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Chew Tobacco: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Cigarettes: | <input type="checkbox"/> <1 pack/day | <input type="checkbox"/> >1 pack/day | <input type="checkbox"/> never |
| Exercise: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Wear Seat Belts: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Other: _____ | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |

Family History: (Check all that apply)

- | | | |
|----------------|---------------------------------|----------------------------------|
| Arthritis: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Cancer: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Diabetes: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Heart Disease: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Hypertension: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Stroke: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Thyroid: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Other: _____ | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |

Occupational Activities: (Check one that best describes your job description)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business Owner | <input type="checkbox"/> Clerical/Secretary | <input type="checkbox"/> Computer User |
| <input type="checkbox"/> Heavy Equipment Operator | <input type="checkbox"/> Daycare/Childcare | <input type="checkbox"/> Construction | <input type="checkbox"/> Health Care Industry |
| <input type="checkbox"/> Food Service | <input type="checkbox"/> Medium Manual Labor | <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Home Services |
| <input type="checkbox"/> Heavy Manual Labor | <input type="checkbox"/> Light Manual Labor | <input type="checkbox"/> Executive/Legal | <input type="checkbox"/> Housekeeper |
| <input type="checkbox"/> Other _____ | | | |

Doctor's Signature _____

Patient Name _____ Date: ____/____/____

Review of Systems - (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular	Past	Present	No	Respiratory	Past	Present	No	Allergic/Immunologic	Past	Present	No
	Poor Circulation					Asthma					Hives
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker											
Jaw Pain				Eyes			No	Ear, Nose and Throat	Past	Present	No
Irregular Heartbeat					Past	Present			Difficulty Swallowing		
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				Psychiatric			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				Gastrointestinal			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				Hematologic			No				
Pinched Nerves					Past	Present		Musculoskeletal			No
Parkinson's				Hepatitis			Past		Present		
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
Weight Loss/Gain				Sweating				Broken Bones			
Low Energy Level								Joints Replaced			
Difficulty Sleeping											

Please list all current medications being taken:

_____	_____
_____	_____
_____	_____

Doctor's Signature _____

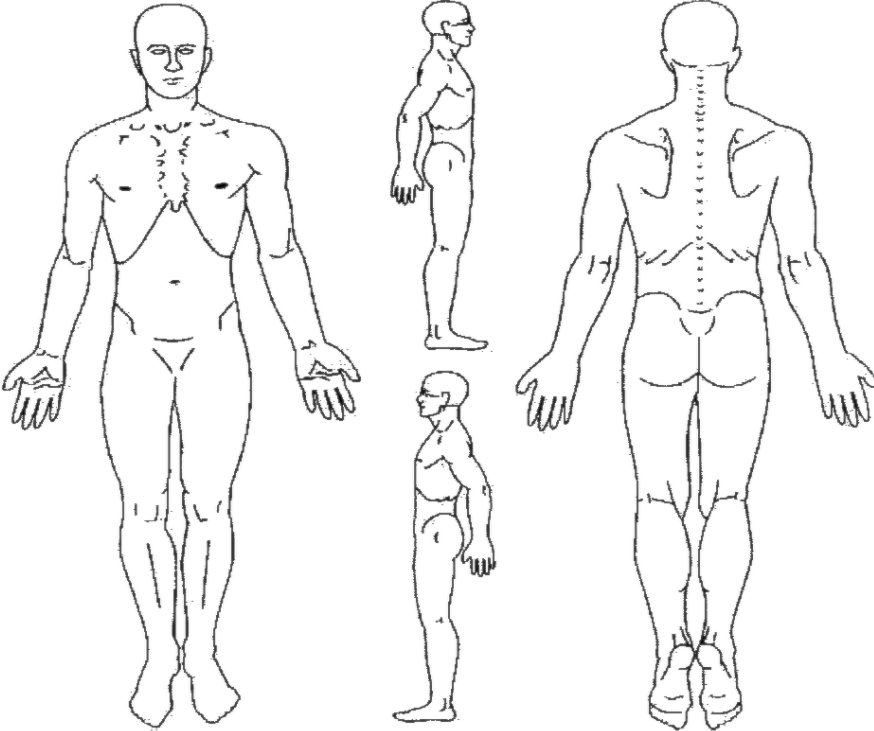
Patient Name _____ Date: ____/____/____

Review of Systems - (continued)

Are you pregnant? Yes No N/A

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N = Numbness B = Burning S = Stabbing T = Tingling A = Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1:

When did your symptoms begin?

Month ____ Day ____ Year _____

Are your symptoms a result of:

- Motor vehicle accident
- Work related accident
- Other: _____

How did your symptoms begin? _____

How often do you experience your symptoms?

- Constantly (76%-100% day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- Sharp
- Dull ache
- Numb
- Shooting
- Burning
- Tingling
- Stabbing
- Other _____

How are your symptoms changing?

- Getting better
- Not changing
- Getting worse

