



Patient Name \_\_\_\_\_

Revision 10.5.2011

### Patient Information

Date: _____	SSN: _____	Birthday: _____
First Name: _____	Middle Name: _____	Last Name: _____
Sex: <input type="radio"/> M <input type="radio"/> F	Height: _____	Weight: _____
Marital Status: <input type="radio"/> Yes <input type="radio"/> No	Spouse Name: _____	# of Children: _____
Home #: _____	Cell #: _____	Work #: _____
Address: _____		
City: _____	State: _____	Zip: _____
Emergency Contact: _____	Emergency Relation: _____	Emergency Phone: _____
Email: _____		

### Referral Information

Referring Physician: _____	Referred Patient: _____	Referred by: _____
Advertisement: <input type="radio"/> Yes <input type="radio"/> No	Advertisement: _____	
Referred Directory: <input type="radio"/> Yes <input type="radio"/> No	Referred Directory: _____	

### Employer Information

Employed: <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Homemaker <input type="radio"/> Unemployed	Employer Name: _____
Employer Address: _____	
Employer City: _____	Employer State: _____ Employer Zip: _____
Occupation: _____	Work Supervisor: _____ Supervisor #: _____
Work Duties: _____	

### Insurance Information

Payment: <input type="radio"/> Personal <input type="radio"/> 3rd Party <input type="radio"/> Self	Resp. for Payment: _____	Responsible Phone : _____
Payment Name: _____	Primary Phone #: _____	Primary ID/Policy: _____
Payment Address: _____		
Payment City: _____	Payment State: _____	Payment Zip: _____
Primary Group #: _____	Primary Name: _____	Primary DOB: _____
Secondary Name: _____	Secondary Phone #: _____	Secondary ID/Policy: _____
Secondary Address: _____		
Secondary City: _____	Secondary State: _____	Secondary Zip: _____
Secondary Group #: _____	Secondary Name: _____	Secondary DOB: _____
Claim #: _____	Claim Contact: _____	Claim Phone #: _____
Attorney Name: _____	Attorney Phone #: _____	

## Complaint Information

Injury Occurred:	<input type="radio"/> Automobile	<input type="radio"/> Work	<input type="radio"/> Third-Party	<input type="radio"/> Other	Injury Date: _____
Injury Origin:	_____				
Desc Discomfort:	_____				
Frequency:	<input type="radio"/> Always	<input type="radio"/> Hourly	<input type="radio"/> Daily	<input type="radio"/> Occasionally	
Interfere w/ Activities:	<input type="radio"/> Yes	<input type="radio"/> No	Affected Sleep:	<input type="radio"/> Yes	<input type="radio"/> No
Missed Work:	<input type="radio"/> Yes	<input type="radio"/> No	Unable to Work from:	_____	Unable to Work til: _____
Affected Appetite:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____	
Reduced Work:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____	
Does it Worsen:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____	
Weather Affects it:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____	
Aggravates Condition:	_____				
Improves Condition:	_____				
Received Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____	
X-rays Taken:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____	
Same Condition Before:	<input type="radio"/> Yes	<input type="radio"/> No	Date:	_____	Practitioner: _____

## History

Last Physical Exam: _____	Primary Phys: _____	Phys Phone #: _____
Phys City: _____	Phys State: _____	Phys Zip: _____
Health Conditions:	_____	
Surgeries/Hosp:	_____	
Previous Chiro Care:	<input type="radio"/> Yes	<input type="radio"/> No
Date:	_____	Explain: _____
Chance Pregnant:	<input type="radio"/> Yes	<input type="radio"/> No
Planning:	<input type="radio"/> Yes	<input type="radio"/> No
Medications:	_____	
Supplements:	_____	
Broken Bones:	<input type="radio"/> Yes	<input type="radio"/> No
Treatment:	<input type="radio"/> Yes	<input type="radio"/> No
Explain:	_____	
Sprains/Strains:	<input type="radio"/> Yes	<input type="radio"/> No
Treatment:	<input type="radio"/> Yes	<input type="radio"/> No
Explain:	_____	
Hospitalized:	<input type="radio"/> Yes	<input type="radio"/> No
Explain:	_____	
Surgery:	<input type="radio"/> Yes	<input type="radio"/> No
Explain:	_____	
Auto Accident:	<input type="radio"/> Yes	<input type="radio"/> No
Treatment:	<input type="radio"/> Yes	<input type="radio"/> No
Explain:	_____	
Struck Unconscious:	<input type="radio"/> Yes	<input type="radio"/> No
Treatment:	<input type="radio"/> Yes	<input type="radio"/> No
Explain:	_____	
Eating Disorder:	<input type="radio"/> Yes	<input type="radio"/> No
Explain:	_____	
Stroke:	<input type="radio"/> Yes	<input type="radio"/> No
Explain:	_____	
Family Health Hist:	_____	

### Patient Social

Alcohol:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Caffeine:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Diet Food Products:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Drugs:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
OTC Stimulants:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Exercise:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Homemade Food:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Processed Food:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Soft Drinks:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Tobacco:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Water:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never					

### Health Checklist

<input type="checkbox"/> Allergies	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Anemia
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Cold Extremities	<input type="checkbox"/> Constipation	<input type="checkbox"/> Cramps
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Digestion Problems
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Excessive Menstruation	<input type="checkbox"/> Eye Pain or Difficulties
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Headache
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Irregular Menstrual Cycle	<input type="checkbox"/> Kidney Infection
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Polio	<input type="checkbox"/> Poor Posture
<input type="checkbox"/> Prostate Trouble	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Spinal Curvatures	<input type="checkbox"/> Sinus Infection	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Stroke	<input type="checkbox"/> Swelling of Ankles
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> Tuberculosis
	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Other:		

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_