PATIENT INFORMATION

Date:_______________________

Name: ____ Age _______

Home Address: ____ Home Phone: ______________________

City, State, Zip: ____

Email Address: ____ Cell Phone: ______________________

Birth Date: ______ / ______ / _______

How did you hear about our office? ____

Main Complaint:____

Is this purpose related to an auto accident / work injury? □ Yes □ No If so, when: ____

When did this condition begin? __________/_____/________ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? ____

Is there anything that has relieved your symptoms? □ Yes □ No Describe: ____

Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the Pain Radiate into your: ___Arm ___Leg ___Does not radiate Is this condition getting worse? □ Yes □ No

How often do you experience these symptoms throughout the day?: 100% 75% 50% 25% 10% Only with Activity

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: ______________________________________

Have you experienced this condition before? □ Yes □ No If so, please explain: ____

Who have you seen for this? ____________________________________ What was done ? ____________________________________

How did you respond? ____

Additional Complaints: ____

Please list any medications currently taking and their purpose: ____

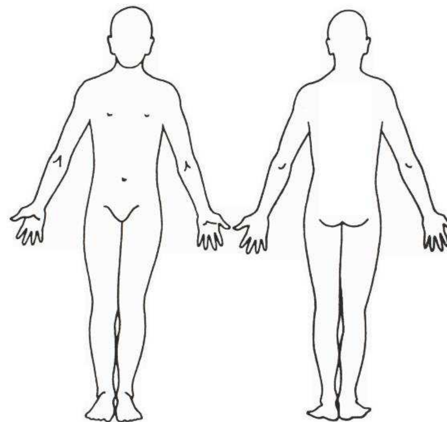
Please list all past surgeries: ____

Please list all previous accidents and falls: ____

Have you had cancer? If , yes what kind ____________________ Have you had a stroke? Yes No If, yes when? ___________

Mark the areas on the body where you feel the described sensations using the appropriate symbols.

Numbness ----
Pins & Needles 0000
Burning xxxx
Aching ****
Stabbing ////



Do you have insurance? □ Yes □ No
Be sure we have a copy of your insurance card.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians. The above information is true and accurate to the best of my knowledge. Chiropractic has only one goal and that is to reduce and eliminate subluxation.

Patient/Guardian Signature:____ Date:____________________