CONFIDENTIAL PATIENT DATA

Today's Date: _____ / ______ / _______

Patient's Legal Name: ________________________________ Patient's Date of Birth: _____ / ______ / _______

Address: ________________________________ City: ____________ State: ________ Zip: _________

Home Phone: (____) ____-_______ Cell :(____) ____-_______ Work Phone: (____) ____-_______

Email Address: ________________________________ Nick Name: ________________

Social Security #:________ - _____- ________ Age: ________ ☐ Male ☐ Female

Marital Status: ☐ Partnered ☐Married ☐Single ☐Divorced ☐Widowed ☐Other ______________

Name of Emergency Contact ________________ relation____________ Phone:(____) ____-_______

Your Occupation____________________ Your Employer:________________

Referred to this Office by: ☐Friend/Family Member - Name________________________

☐Search Engine ☐ Email/ Mail ☐Clinic Location ☐Facebook/Instagram ☐Other______________

Payment for Services will be by: ☐Cash/Check /Credit Card ☐Health Insurance Policy & Cash/Check/Credit

☐Automobile Insurance Policy ☐Worker's Compensation Policy

Name of Insurance Co.:____________________ Subscriber/ Primary Ins. Carrier ______________

Subscriber's Date of Birth ____ / _____ / ______ Subscriber's Employer: (if different from above) ______________

Do you have a secondary insurance policy? ☐No ☐Yes & Name ________________________

☐Provided Insurance Card & Identification (Please provide these to the office staff to make a copy for your records. Thank you!)

HEALTH HISTORY

Have you been treated by a physician for any health condition in the last year? ☐Yes ☐No

Name & Location of Doctors previously seen for any/all present health conditions	Health condition	Approximate date last seen

Are you allergic to any medications? ☐NO ☐YES & WHAT KIND?________________________

Are you taking any medications? ☐NO ☐YES & WHAT KIND?________________________

Are you Pregnant? ☐YES ☐NO ☐MAYBE First day of your Last Menstrual Period _____ / _____ / _______

Do you have any metal implants? ☐No ☐Yes Describe : ________________________

Have you ever been shot by a gun? ☐No ☐Yes _____ / _____ / _______

Patient's Name (Please Print)____

MEDICAL HISTORY

FAMILY MEDICAL HISTORY (Please indicate which conditions have been experienced by you or your parents by marking appropriate boxes)

Father	Mother	Self	Father	Mother	Self	Father	Mother	Self
❑	❑	❑Aids	❑	❑	❑epilepsy	❑	❑	❑multiple sclerosis
❑	❑	❑allergies	❑	❑	❑German measles	❑	❑	❑polio
❑	❑	❑arthritis	❑	❑	❑high blood pressure	❑	❑	❑poor circulation
❑	❑	❑asthma	❑	❑	❑HIV/ARC	❑	❑	❑reproductive disorder
❑	❑	❑bone fracture	❑	❑	❑heart trouble	❑	❑	❑rheumatic fever
❑	❑	❑cancer	❑	❑	❑headaches	❑	❑	❑rheumatism
❑	❑	❑concussion	❑	❑	❑hepatitis	❑	❑	❑scarlet fever
❑	❑	❑convulsions	❑	❑	❑indigestion	❑	❑	❑sinus trouble
❑	❑	❑diabetes	❑	❑	❑kidney disorder	❑	❑	❑ tuberculosis
❑	❑	❑dislocated joints	❑	❑	❑muscular dystrophy			

SURGICAL HISTORY:

1.______________________________Date:_____/_____/_______

2.______________________________Date:_____/_____/_______

3.______________________________Date:_____/_____/_______

4.______________________________Date:_____/_____/_______

ACCIDENT HISTORY:

1. ❑Job ❑Auto ❑Other Date: _____ / _____ / _______
2. ❑Job ❑Auto ❑Other Date: _____ / _____ / _______
3. ❑Job ❑Auto ❑Other Date: _____ / _____ / _______

CURRENT COMPLAINTS:

SYMPTOMS DEVELOPED FROM: ☐JOB RELATED INJURY ☐AUTO ACCIDENT ☐OTHER ☐ACCIDENT ☐ILLNESS ☐UNKNOWN CAUSE ☐GRADUAL ONSET

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS: Rate your symptoms 1-10 (with 1 being least serious)

❑Headache- Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Neck- Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Shoulder- Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Pain /tingling down arm- R / L Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Mid Back- Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Low Back- Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Hip- Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Pain down Leg- Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Other ______________ Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Other ______________ Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10

Symptoms Began: ______ / ______ / ________ SYMPTOMS ARE WORSE IN ☐MORNING ☐AFTERNOON ☐NIGHT

SYMPTOMS HAVE PERSISTED FOR # ___HOUR(S) ___DAY(S) __WEEK(S) __MONTH(S) __YEAR(S)

SYMPTOMS/COMPLAINTS: ☐COME & GO ☐ARE CONSTANT ☐ ARE NEARLY CONSTANT

HAVE YOU EVER HAD THIS BEFORE: ☐NO ☐YES & WHEN?______________________________

Please check the following activities that **AGGRAVATE** your condition: ❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD ❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING ❑WORK DUTIES

Please check the following activities that **RELIEVE** your condition: ❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING ❑CHIROPRACTIC TREATMENT

ADDITIONAL SYMPTOMS you may be experiencing: ❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss /confusion ❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever ❑head seems too heavy ❑headaches ❑insomnia (trouble sleeping) ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

The above information is accurate and complete to the best of my knowledge.

Patient's Signature: ____ Date:__________________