PATIENT INFORMATION FORM

Name: _____ Today's Date: ___/___/___

SSN ☐☐☐☐☐☐☐☐☐ Birth Date: ___/___/___ Age: ___ Gender: __F __M

Phone number: _____ Home/ cell /work Email: _____

Can we text you for appointment reminders? Y N Cell phone provider: _____

Emergency Contact Name/Phone Number: _____

Name of Spouse _____ Spouse's Date of Birth ___/___/___

If you are under 18 years of age, who are your legal parents or guardian?
Father: _____ Date of Birth: ___/___/___ Phone: _____
Mother: _____ Date of Birth: ___/___/___ Phone:_____
Guardian: _____ Date of Birth: ___/___/___ Phone: _____

CURRENT ADDRESS / MAILING
Street _____
City _____ State _____ Zip _____

Describe your condition, symptoms, or the purpose of this appointment:_____
_____
_____

Is your current health complaint directly related to a workplace accident? (ie. Did you get hurt while at work?)

☐Yes ☐No If **yes**, what was the date of your work injury? _____

If **yes**, have you filed a formal report of your workplace injury with a supervisor? ☐Yes ☐No
If **yes**, Please briefly describe your workplace accident: _____
_____

Have you missed any days of work from your injury ☐Yes ☐No
If **yes**, how many days of work have you missed because of your injury? _____

Is your condition or injury due to a recent motor vehicle accident? (Are you here because you were in a car crash?)

☐ YES ☐ NO
If **yes**, what was the date of the car accident? _____

If **yes**, have you filed a claim with YOUR automobile insurance company? ☐ YES ☐ NO
If **yes**, whose car were you in at the time of the accident? (personal, work vehicle, friend's car, etc.)_____

Have you ever had previous Chiropractic Care: __Yes__ No

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

1. Name: _____ Type of Practice: _____
Date of First Visit: __/__/___ Date of Last Visit:__/__/__ How many times did you treat with this doctor? _____
Are you still actively treating with this doctor? ☐YES ☐NO Did the treatment help? ☐ YES ☐ NO

2. Name: _____ Type of Practice: _____
Date of First Visit: __/__/___ Date of Last Visit:__/__/___ How many times did you treat with this doctor?_____
Are you still actively treating with this doctor? ☐YES ☐NO Did the treatment help? ☐ YES ☐ NO

Please list any special tests you've had for this injury or condition (Xrays, MRI, bone scans, etc.)
Special Test: _____ Approx. Date:_____ Where?:_____
Special Test: _____ Approx. Date:_____ Where?:_____
Special Test: _____ Approx. Date:_____ Where?:_____

What is the name of your primary care physician? _____
Primary care doctors location:_____ Phone #_____
Last Visit Date (approx.) _____

Have you ever been diagnosed by a doctor with the following conditions?
Bulging Discs: Yes No
Herniated Discs: Yes No
Arthritis in your spine: Yes No
Degenerated Discs: Yes No

Health History: (Please use back of form if necessary)

Allergy	***Reaction***	***Severity (mild/moderate/severe)***
Example: Penicillin	**hives**	**mild**

Please list all Surgeries that you have had:

Surgery	***Date (Approx.)***
Example: Appendix removal	**January 2005**

Please list all Hospitalizations that you've had:

Date (Approx.)	***Reason***	***Hospital***
Example: July 2004	**Pneumonia**	**St. Lukes Monroe**

Please list all Major Injuries/Illness that you've had:

Date (Approx.)	***Injury/Illness***
Example: July 2004	**Motor cycle accident/ Ovarian Cancer**

Family History (please circle)

Mother: Living / Deceased Cancer / Diabetes / Heart Disease / Stroke Other:_____

Father: Living / Deceased Cancer / Diabetes / Heart Disease / Stroke Other:_____

Social

Current Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Smoking Status: ☐Never smoker ☐Current every day smoker ☐Current some day smoker ☐Former smoker

Alcohol Status: ☐ No consumption ☐ Casual consumption ☐ Moderate consumption ☐ Heavy consumption

Caffeine use (drinks per day): ☐None ☐Less than 3/day ☐Between 3- 6/day ☐More than 6/day

Illicit drug use: ☐ None ☐ Former illicit drug use ☐ Current illicit drug use

Exercise: ☐ Never ☐ Daily ☐ Weekly

Occupational History

Start date (Approx.)	***End Date(Approx.)***	***Occupation***
Ex. July 2005	**May 2014**	**Machinist/Student/Legal Secretary**

Implantable Devices

Date (Approx.)	***Implant/device***
Example: July 2004	**Right hip replacement**

Women only: Are you currently pregnant? Yes/No. If yes, how many weeks_____

INSURANCE BENEFIT VERIFICATION

Would you like us to do a one-time review your reported insurance benefits with you before any care is rendered today? (check one)

☐ Yes
☐ No

Would you like your insurance benefits printed?

☐ Yes
☐ No

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REVIEW OF SYSTEMS

In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ❑ No Problems

Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____

Ears, Nose, Mouth & Throat ❑No Problems

Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems

Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking.
Other: _____

Resp. (Lungs & Breathing) ❑ No Problems

Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) ❑ No Problems

Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ❑ No Problems

Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence.
Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems

Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain.
Other: _____

Integumentary (Skin, Hair & Breast) ❑ No Problems

Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes.
Other: _____

Neurologic (Brain & Nerves) ❑ No Problems

Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems

Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions.
Other: _____

Endocrinologic (Glands) ❑ No Problems

Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive.
Other: _____

Hematologic (Blood/Lymph) ❑ No Problems

Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas.
Other: _____

Allergic/Immunologic ❑ No Problems

Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV.
Other: _____

Signature Patient: _____ Date: _____