

ONE ABOUT YOU

Today's Date: ___/___/_____

Patient: _____
Last First MI

Name you prefer _____

Birthdate: ___/___/___ Age: _____ M F

SS#: _____

Mailing address: _____

City _____

State _____ Zip _____

Home Phone: _____

Work Phone: _____

Other Phone: _____

E-mail: _____

Referred By: _____

Employer: _____

Employer Addr: _____

Marital Status: S M W D DP

Name of Spouse _____

Number of Children _____

Spouse's Address _____

Spouse Telephone _____

Spouse's Occupation _____

Emergency Contact _____

Telephone _____

Person responsible for payment: Self

Address: _____

Phone: _____

TWO PAST HISTORY

Past chiropractic care? Yes No

If yes, who/where? _____

Name & phone# of your primary care physician?

Last Physical Examination ___/___/_____

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

If yes, explain _____

What medication are you taking? _____

Have ever had: Surgery Yes No
Fractures Yes No
Car Accidents Yes No
Falls Yes No
On-Job Injury Yes No

Describe: _____

Family history of: Heart disease Yes No
Cancer Yes No
Diabetes Yes No
Arthritis Yes No
Back problems Yes No

Other: _____

Previous serious illness/ hospitalization:

(Please date & describe) _____

If you are female, are you possibly pregnant?
Yes No

Date of last menstrual period _____

Emergency New Injury Old Injury Chronic Pn Wellness

Major Symptom _____

Date symptoms first began: ___/___/_____

How did your symptoms first begin? _____

Other Symptoms _____

Pains is: Constant Intermittent

Is your condition getting? Worse Better Same

What activities aggravate your condition? _____

What activities lessen your symptoms? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with:

work Yes No

sleep Yes No

routine Yes No

Other doctors seen for this condition _____

List home remedies tried _____

Have you ever had (P - Past) or do now have (C - Current) any of the following?

- Abnormal Menstruation P C
- Anemia P C
- Arm or Shoulder Pain P C
- Arm/Shoulder Weak P C
- Arthritis or Bursitis P C
- Asthma or Emphysema P C
- Blood in Urine or Stool P C
- Breast Problems P C
- Buzzing or Ringing in Ears P C
- Chest Pain P C
- Cold Feet or Hands P C
- Constipation/Diarrhea P C
- Depression P C
- Diabetes P C
- Difficulty/Pain with Urination P C
- Digestive/Eating Probs: P C
- Dizziness/Light Headed P C
- Face Flushed P C
- Fainting or Convulsions P C
- Fatigue or Weakness P C
- Fever P C
- Headaches P C
- Heart Trouble or Stroke P C
- High Blood Pressure P C
- Kidney Trouble P C
- Leg Cramps or Swelling P C
- Leg or Foot Pain P C
- Loss of Balance or Coordin. P C
- Loss of Energy P C
- Loss of Memory P C
- Loss of Smell P C
- Loss of Taste P C
- Low Back Pain or Stiff. P C
- Mid Back Pain or Stiff. P C
- Nausea or Vomiting P C
- Neck Pain or Stiffness P C
- Nervousness P C
- Numbness in Fingers P C
- Numbness in Toes P C
- Pain or Diff. Breathing P C
- Pins & Needles in Arms P C
- Pins & Needles in Legs P C
- Pneumonia P C
- Prostate Problems P C
- Rashes P C
- Rheumatic Fever P C
- Seizures P C
- Sexual Dysfunction P C
- Sinus Prob. or Allergies P C
- Sleeping Problems P C
- Stomach Upset/Pain P C
- Tension or Irritability P C
- Thyroid Problems P C
- Tuberculosis P C

Check if you have had any of the following in the last 30 days:

Check if you have ever had any of the following:

- Pain worse at night
- Constant pain unrelated to motion
- Unexplained weight loss
- Loss of bowel/bladder control
- Bacterial infection
- Surgery
- Fever or chills
- Visit to ER, Urgent Care or Hospital
- History of Cancer
- History of HIV
- Use of Steroids
- Use of IV Drugs
- Blood Transfusions

Lifestyle.

- Do you? Smoke Abuse alcohol Use rec. drugs
- Exercise Level: Heavy Moderate Light Non-existent
- Diet Quality: Good Average Poor; Veget./Vegan
- Stress Level: High Average Low

*NOTICE TO NEW PATIENTS: Full payment is due at the end of each visit for services rendered.

AGREEMENT FOR PATIENTS WITH INSURANCE: I will pay all co-payments or unmet deductible balances at the time of services, and I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this office does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on my indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any information pertinent to my case to the insurance company.

Signature _____ Date _____

Adult Patient Parent/Guardian Spouse

(office use) ID: _____