

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Legal Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

E-mail _____

Occupation _____ Employer _____ Date of Birth _____ Age _____

Name of Spouse/Nearest Relative _____ Phone of Spouse/Nearest Relative _____

Is condition due to injury from employment? _____ or auto accident? _____

Date of first symptoms or accident happened? _____ Patient had same/similar condition? ()yes ()No

If yes when and describe _____

Have you lost any days from work? () yes () no If yes, when? (date) _____

Referred to our office by _____ If female, are you pregnant? _____

Name of Physician _____ Date of last physical examination _____

What operations have you had and when? _____

Serious illnesses, what and when? _____

Ever had Chiropractic care? _____ If yes, Doctor's name and when _____

Have you ever suffered from: (if yes, circle the disorder)

- | | | | | |
|--------------------|---------------------|---------------------|-----------------------|----------------------|
| Allergy | Poor posture | Tuberculosis | Itching | Dizziness |
| Fatigue | Sciatica | Bruise easily | Varicose veins | Headache |
| Swollen Joints | Nose bleeds | Frequent urination | Loss of sleep | Colon Trouble |
| Sinus infection | Kidney infect/stone | Ulcers | Diarrhea | High blood pressure |
| Prostate trouble | Nervous/Depressed | Difficult digestion | Arthritis | Low blood pressure |
| Numbness | Hemorrhoids | Pain over heart | Excess menstrual flow | Asthma |
| Cramps or backache | Nausea | Swelling of ankles | Poor circulation | Hot flashes |
| Bursitis | Rapid heart beat | Irregular cycle | Foot trouble | Frequent colds |
| Slow heart beat | Lumps in breasts | Low back pain | Deafness | Anemia |
| Alcoholism | Neck pain/stiff | Ear noises | Stroke | Diabetes |
| Enlarged thyroid | Chest pain | Polio | Eye pain | Difficulty breathing |
| Failing Vision | Pleurisy | Venereal Disease | Cancer | |

Habits:	Heavy	Moderate	Light	None	Do you wear
Alcohol	_____	_____	_____	_____	heel lifts ____
Coffee	_____	_____	_____	_____	Sole lifts ____
Tobacco	_____	_____	_____	_____	Inner soles ____
Drugs	_____	_____	_____	_____	Arch supports ____
Exercise	_____	_____	_____	_____	
Sleep	_____	_____	_____	_____	
Appetite	_____	_____	_____	_____	
Supplements	_____	_____	_____	_____	

Purpose of this appointment? (major complaint) _____

What activities aggravate your condition? _____

Is condition getting progressively worse? Yes ____ No ____ Constant ____ Sporadic ____

Is condition interfering with your: work ____ Sleep ____ Daily routine ____ Other _____

How long has it been since you really felt good? _____

What do you believe is wrong with you? _____

Other Doctors seen for this condition? _____

Have you been treated for any health conditions by a physician in the last year? If yes, describe _____

What medications or over- the- counter drugs are you taking? _____

PAYMENT IS EXPECTED AT THE TIME OF THE VISIT. OUR financial policy will be explained and given to you in writing before you leave the office today. If you have any questions regarding how this policy works, feel free to ask before you see the Doctor.

Patient signature _____ Date _____

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