Patient Information

Legal First Name: _____ MI: _____ Last Name: _____

Street: _____Apt: _____

City: _____ State: _____ Zip: _____

Social Security #:_____ Marital Status: S M W D Spouse:_____

Language: _____English _____ Spanish _____ Indian _____ Japanese _____ Chinese _____ Korean _____ French _____ German _____ Russian _____ Other_____

Race: _____ White _____American Indian or Alaska Native _____ Asian _____Native Hawaiian/Other Pacific Islander _____ Black or African American _____ Decline to Answer _____Other_____

Ethnicity: _____ Hispanic or Latino _____Not Hispanic or Latino _____ Decline to Answer

DOB: _____ Home Phone: _____ Work Phone:_____

Cell Phone: _____ Cell Carrier_____

Please check your contact preference: _____Hm _____ Wk _____ Cell _____Email _____ Postal Mail

Email (hm): _____ Email (wk): _____

Emergency Contact:_____ Phone Number: _____

Whom may we thank for referring you to our office? _____

Occupation: _____ Employer: _____

Employer Address: _____

Insurance Information

We will make a copy of your insurance card/s. However, please complete the following information.

Are you the policy holder? Y N If no, who is policy holder: Spouse Parent Employer Other

Policy Holder's Name:

First Name: _____ M.I. _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Policy Holder's Employer: _____

Do you have secondary insurance coverage? Y N If yes, please complete the following:

Policy Holder's Name:

First Name: _____ M.I. _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Policy Holder's Employer: _____

Case History

If you have no symptoms and are here for wellness services, please check here _____ "**Wish to have Chiropractic Wellness Services"** and skip to "**Family Health Profile".** Others need to briefly describe the chief area of complaint including the effect it has had on your life.

_____

_____

If you are experiencing pain, is it (circle all that apply):

Sharp Dull Comes and goes Travels Constant

Since the problem started, it is (circle one): About the same Getting better Getting worse

What makes it worse: _____

Yes, it interferes with (circle all that apply): work sleep walking sitting hobbies leisure

Please circle all symptoms you have ever had, even if they do not seem related to your current problem

Headaches	pins and needles in legs	fainting	neck pain
Loss of smell	pins and needles in arms	back pain	loss of balance
Dizziness	buzzing in ears	ringing in ears	nervousness
Fatigue	numbness in toes	loss of taste	stomach upset
Depression	numbness in fingers	irritability	tension
Sleeping problems	neck stiff	cold hands	cold feet
Diarrhea	constipation	heartburn	hot flashes

Are you seeing anyone else for other problems or health conditions? □ **Yes** □ **No**
Please list the problem/s, date problem/s began, and Provider/s treating you for the condition/s:

_____

_____

Past health history

Have you…	**Yes**	**No**	**If yes, include date & provider seen**
...been diagnosed with Diabetes? Type I____or Type II_____	□	□	_____
…been treated for hypertension?	□	□	_____

Do you smoke? □Never □Former Smoker □Current/Every Day Smoker □Current Some Day Smoker

Medications
What medications are you currently taking? Include vitamins, herbs, minerals…
List Date Started, Brand Name, Generic Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by
Please be as specific as possible

_____

_____

_____

_____

Do you have allergies? □Food □Environmental □Medication (List Type of Allergy and Reaction)

_____

_____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____

Signature Date