

Phone Number: _____

Patient Information

Date: _____	SSN: _____	Birthday: _____
First Name: _____	Middle Name: _____	Last Name: _____
Sex: <input type="radio"/> M <input type="radio"/> F	Height: _____	Weight: _____
Marital Status: <input type="radio"/> Yes <input type="radio"/> No	Spouse Name: _____	# of Children: _____
Home #: _____	Cell #: _____	Work #: _____
Address: _____		
City: _____	State: _____	Zip: _____
Emergency Contact: _____	Emergency Relation: _____	Emergency Phone: _____
Email: _____		

Referral Information

Referring Physician: _____	Referred Patient: _____	Referred by: _____
Advertisement: <input type="radio"/> Yes <input type="radio"/> No	Advertisement: _____	
Referred Directory: <input type="radio"/> Yes <input type="radio"/> No	Referred Directory: _____	

Employer Information

Employed: <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Homemaker <input type="radio"/> Unemployed	Employer Name: _____	
Employer Address: _____		
Employer City: _____	Employer State: _____	Employer Zip: _____
Occupation: _____	Work Supervisor: _____	Supervisor #: _____
Work Duties: _____		

Insurance Information

Payment: <input type="radio"/> Personal <input type="radio"/> 3rd Party <input type="radio"/> Self	Resp. for Payment: _____	Responsible Phone: _____
Payment Name: _____	Primary Phone #: _____	Primary ID/Policy: _____
Payment Address: _____		
Payment City: _____	Payment State: _____	Payment Zip: _____
Primary Group #: _____	Primary Name: _____	Primary DOB: _____
Secondary Name: _____	Secondary Phone #: _____	Secondary ID/Policy: _____
Secondary Address: _____		
Secondary City: _____	Secondary State: _____	Secondary Zip: _____
Secondary Group #: _____	Secondary Name: _____	Secondary DOB: _____
Claim #: _____	Claim Contact: _____	Claim Phone #: _____
Attorney Name: _____	Attorney Phone #: _____	

Complaint Information

Injury Occurred:	<input type="radio"/> Automobile	<input type="radio"/> Work	<input type="radio"/> Third-Party	<input type="radio"/> Other	Injury Date:	_____
Injury Origin:	_____					
Desc Discomfort:	_____					
Frequency:	<input type="radio"/> Always	<input type="radio"/> Hourly	<input type="radio"/> Daily	<input type="radio"/> Occasionally		
Interfere w/ Activities:	<input type="radio"/> Yes	<input type="radio"/> No	Affected Sleep:	<input type="radio"/> Yes	<input type="radio"/> No	
Missed Work:	<input type="radio"/> Yes	<input type="radio"/> No	Unable to Work from:	_____	Unable to Work til:	_____
Affected Appetite:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Reduced Work:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Does it Worsen:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Weather Affects it:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Aggravates Condition:	_____					
Improves Condition:	_____					
Received Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
X-rays Taken:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Same Condition Before:	<input type="radio"/> Yes	<input type="radio"/> No	Date:	_____	Practitioner:	_____

History

Last Physical Exam:	_____	Primary Phys:	_____	Phys Phone #:	_____		
Phys City:	_____	Phys State:	_____	Phys Zip:	_____		
Health Conditions:	_____						
Previous Chiro Care:	<input type="radio"/> Yes	<input type="radio"/> No	Date:	_____	Explain:	_____	
Chance Pregnant:	<input type="radio"/> Yes	<input type="radio"/> No	Planning:	<input type="radio"/> Yes	<input type="radio"/> No		
Medications:	_____						
Supplements:	_____						
Broken Bones:	<input type="radio"/> Yes	<input type="radio"/> No	Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____
Sprains/Strains:	<input type="radio"/> Yes	<input type="radio"/> No	Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____
Hospitalized:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____			
Surgery:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____			
Auto Accident:	<input type="radio"/> Yes	<input type="radio"/> No	Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____
Struck Unconscious:	<input type="radio"/> Yes	<input type="radio"/> No	Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____
Eating Disorder:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____			
Stroke:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____			
Family Health Hist:	_____						

Patient Social

Alcohol: Daily Weekly Occasion Never
Diet Food Products: Daily Weekly Occasion Never
OTC Stimulants: Daily Weekly Occasion Never
Homemade Food: Daily Weekly Occasion Never
Soft Drinks: Daily Weekly Occasion Never
Water: Daily Weekly Occasion Never

Caffeine: Daily Weekly Occasion Never
Drugs: Daily Weekly Occasion Never
Exercise: Daily Weekly Occasion Never
Processed Food: Daily Weekly Occasion Never
Tobacco: Daily Weekly Occasion Never

Health Checklist

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Cold Extremities | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cramps |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestion Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Excessive Menstruation | <input type="checkbox"/> Eye Pain or Difficulties |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Irregular Menstrual Cycle | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Polio | <input type="checkbox"/> Poor Posture |
| <input type="checkbox"/> Prostate Trouble | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Infection | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Spinal Curvatures | <input type="checkbox"/> Stroke | <input type="checkbox"/> Swelling of Ankles |
| <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Other: _____ | | |

Patient Symptoms:

Patient Signature: _____

Date: _____