

## Patient Introduction

PLEASE COMPLETE ALL QUESTIONS

1. Name \_\_\_\_\_ 2. Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ 3. Age \_\_\_\_
4. Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
5. Home Phone ( ) \_\_\_\_\_ 6. Cell Phone ( ) \_\_\_\_\_
7. E-mail Address \_\_\_\_\_
8. Personal Contact (not living with you): Name \_\_\_\_\_ Phone Number( ) \_\_\_\_\_
9. Is it ok to e-mail you with health tips? **Y N** circle 10. Occupation \_\_\_\_\_
11. Employer's name, address, phone \_\_\_\_\_
12. Marital Status **S M W D** circle 13. Spouse's Name \_\_\_\_\_
14. Do you have health insurance **Y N** circle Name of Insurance: \_\_\_\_\_
15. Policy # \_\_\_\_\_ 16. Social Security # \_\_\_\_\_
17. Referred By: \_\_\_\_\_
18. Ever been to a chiropractor before? **Y N** circle If yes who/where? \_\_\_\_\_
19. Are you on Medicare/Medicaid ? **Y N** circle Medicare# \_\_\_\_\_ Medicaid# \_\_\_\_\_

Please indicate if you are here for care because of:  On the job injury  Auto accident  At home injury

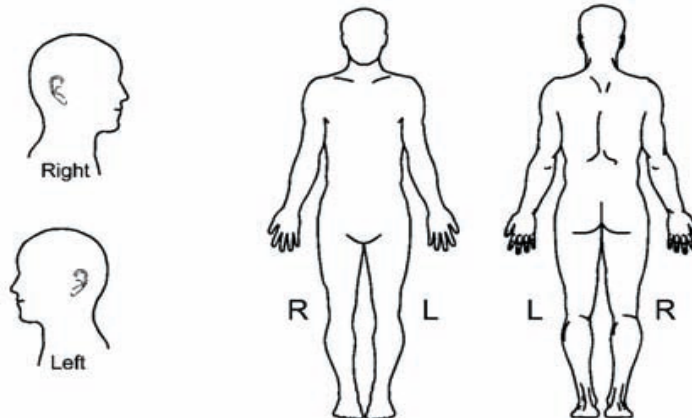
Date of Injury \_\_\_\_\_ Name of person responsible \_\_\_\_\_

Their Insurance Co. \_\_\_\_\_ Attorney's Name \_\_\_\_\_

Attorney's Address \_\_\_\_\_ Dates you have taken off work \_\_\_\_\_

On the diagram below, please outline the areas of pain or discomfort. Use the following Symbols:

A= Aching B= Burning C=Cold H= Hypersensitivity N=Numbness R= Throbbing S= Stabbing T= Tingling



List your major complaint in order of importance and rate the pain on the pain scale (purpose of this appointment)

- 1. \_\_\_\_\_ Less Pain [ 0 1 2 3 4 5 6 7 8 9 10 ] Worst Pain
2. \_\_\_\_\_ Less Pain [ 0 1 2 3 4 5 6 7 8 9 10 ] Worst Pain
3. \_\_\_\_\_ Less Pain [ 0 1 2 3 4 5 6 7 8 9 10 ] Worst Pain
4. \_\_\_\_\_ Less Pain [ 0 1 2 3 4 5 6 7 8 9 10 ] Worst Pain

Please check all of the following symptoms and signs which you now have or have had within the last 6 months. An understanding of your health status will facilitate care.

A. Musculo-skeletal

- O Weakness
O Twitching
O Stiff neck
O Neck pain
O Muscle spasm
O Grating and / or grinding in neck
O Pain in shoulders and arms
O Tightening of shoulder muscles
O Pins & needles in arms and hands
O Cold Hands
O Backache
O Swollen joints
O Painful joints
O Pain in legs
O Pins and needles in legs
O Tremors
O Foot trouble
O Cold feet
O Painful tail bone
O Hernia
O Spinal curvature
O Faulty posture

- O Loss of sleep
O Fatigue
O Nervousness
O Allergy
O Wheezing
O Neuralgia
O Diabetes
O Cancer
O Arthritis
O Crying spells
O Frequent anger
O Fear

C. Gastro-Intestinal

- O Poor Appetite
O Poor digestion
O Excessive hunger
O Belching or gas
O Nausea
O Vomiting
O Vomiting blood
O Pain over stomach
O Constipation
O Diarrhea
O Colon trouble
O Hemorrhoids (piles)
O Liver trouble
O Jaundice
O Gall bladder trouble
O Stomach trouble

D. Cardio-Vascular

- O Rapid heart beat
O Slow heart beat
O High blood pressure

- O Low blood pressure
O Pain over heart
O Previous heart trouble
O Swelling of ankles
O Poor circulation
O Varicose veins
O Strokes

E. Eye, Ear, Nose, Throat

- O Poor Vision
O Crossed eyes
O Pain in eyes
O Deafness
O Earache
O Ear discharge
O Nasal discharge
O Nasal obstruction
O Nose bleeds
O Sore throat
O Hoarseness
O Hay Fever
O Asthma
O Frequent colds
O Tonsillitis
O Sinus trouble
O Thyroid trouble

F. Skin

- O Skin eruptions
O Itching
O Bruising
O Dryness
O Boils
O Sensitive skin
O Hives or allergy

- O Eczema
O Psoriasis

G. Respiratory

- O Chronic cough
O Spitting blood
O Spitting phlegm
O Chest pain
O Difficulty breathing
O Lung problems

H. Genito-Urinary

- O Frequent urination
O Painful urination
O Blood in urine
O Kidney infection
O Bladder infection
O Bed wetting
O Inability to control urine
O Prostate trouble

I. For women only

- O Painful periods
O Excessive flow
O Irregular cycles
O Hot flashes
O Cramps or backaches
O Miscarriage
O Vaginal discharge
O Pregnant at this time

Have you ever had any falls, auto accidents, or injuries? Y N circle Please describe injury\_\_\_\_\_

Month, Year\_\_\_\_\_ Type of Accident\_\_\_\_\_

Have you ever had surgery? Y N circle Please describe\_\_\_\_\_

Month, Year\_\_\_\_\_ Comments\_\_\_\_\_

Are you currently taking any medications? Y N circle Please list them\_\_\_\_\_

Payment is expected at time of visit!

Name of Person Responsible for Payment\_\_\_\_\_ I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature\_\_\_\_\_ (IF PATIENT IS A MINOR, NAME OF PARENT, GUARDIAN, ETC