CONFIDENTIAL PATIENT INFORMATION

Date _____

Name _____ Soc. Sec No. _____ Home Phone _____

Address _____ City _____ Zip _____

Age _____ Birth Date _____ HT _____ WT _____ Marital: M S W D How many children? ____

Occupation _____ Employer _____

Address _____ Office Phone _____

Insured's name if patient is a dependent _____ Soc. Sec. No. _____

Name of Insurance Company _____ Address _____

Name of Wife or Husband _____ Occupation _____

Employer _____ Address _____

Patient's nearest relative _____ Address _____ Phone _____

Referred by _____

Is condition due to injury or sickness arising out of patient's employment? ❑ Yes ❑ No

Date symptoms appeared or accident happened _____

Patient ever had same or similar condition? ❑ Yes ❑ No If yes, when and describe _____

_____

Have you lost any days from work? _____

Date of last physical examination _____ Female: Are you pregnant? _____

What operations have you had _____

Serious illness _____

Have you ever been under Chiropractic Care ❑ *Yes* ❑ *No* *Doctor's Name* _____

Have you ever suffered from: P= Previously C= Currently

P	C	
❑	❑	Allergy
❑	❑	Dizziness
❑	❑	Fatigue
❑	❑	Headache
❑	❑	Loss of sleep
❑	❑	Ulcers
❑	❑	Nervousness/Depression
❑	❑	Numbness
❑	❑	Arthritis
❑	❑	Bursitis
❑	❑	Foot trouble
❑	❑	Low back pain

Tingling or numbness in:

P	C		P	C	
❑	❑	Shoulders	❑	❑	Hips
❑	❑	Arms	❑	❑	Legs
❑	❑	Elbows	❑	❑	Knees
❑	❑	Hands	❑	❑	Feet

P	C	
❑	❑	Neck pain or stiffness
❑	❑	Poor posture
❑	❑	Sciatica
❑	❑	Spinal curvatures
❑	❑	Swollen joints
❑	❑	Colon trouble
❑	❑	Diarrhea
❑	❑	Difficult digestion
❑	❑	Hemorroids
❑	❑	Nausea
❑	❑	Asthma
❑	❑	Colds
❑	❑	Deafness
❑	❑	Ear noises
❑	❑	Enlarged Thyroid
❑	❑	Eye pain
❑	❑	Failing vision

P	C	
❑	❑	Venereal Disease
❑	❑	Tuberculosis
❑	❑	Bruise easily
❑	❑	Hay fever
❑	❑	Nosebleeds
❑	❑	Sinus infection
❑	❑	High blood pressure
❑	❑	Low blood pressure
❑	❑	Pain over heart
❑	❑	Poor circulation
❑	❑	Rapid heart beat
❑	❑	Slow heart beat
❑	❑	Anemia
❑	❑	Stroke
❑	❑	Chest Pain
❑	❑	Difficult breathing
❑	❑	Pleurisy

P	C	
❑	❑	Spitting
❑	❑	Itching
❑	❑	Varicose veins
❑	❑	Bed-wetting
❑	❑	Frequent urination
❑	❑	Kidney infection or stone
❑	❑	Prostate trouble
❑	❑	Cramps or backache
❑	❑	Excessive menstrual flow
❑	❑	Hot flashes
❑	❑	Irregular cycle
❑	❑	Lumps in breast
❑	❑	Alcoholism
❑	❑	Diabetes
❑	❑	Polio
❑	❑	Swelling of ankles
❑	❑	Cancer

HABITS:	Heavy	Moderate	Light	None
Alcohol	____	____	____	____
Coffee	____	____	____	____
Tobacco	____	____	____	____
Drugs	____	____	____	____
Exercise	____	____	____	____
Sleep	____	____	____	____
Appetite	____	____	____	____

Do you now take vitamins or minerals? ❑ Yes ❑ No

Do you think you may need to take vitamins or minerals? ❑ Yes ❑ No

Are you wearing:
❑ Heel lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports