

## PATIENT INFORMATION

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Patient SS # \_\_\_\_\_  
Address \_\_\_\_\_  
Street City State Zip  
Phone # (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_ Ext \_\_\_\_\_  
Sex:  M  F Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status:  Single  Married  Widowed  Separated  Divorced  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_ Employer Phone \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_  
Email Address: \_\_\_\_\_ Whom May we thank for referring you? \_\_\_\_\_  
Family (Parents, Siblings) Health History \_\_\_\_\_

## MAJOR MEDICAL INSURANCE

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_  
Insured's Employer \_\_\_\_\_ Relationship to Patient:  Self  Spouse  Child  Other  
Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
Is Patient covered by additional insurance  Yes  No If Yes  
Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_  
Insured's Employer \_\_\_\_\_ Relationship to Patient:  Self  Spouse  Child  Other

## ACCIDENT INFORMATION

Is Condition due to an accident:  Yes  No Date \_\_\_\_\_ Type of accident:  Auto  Work  Home  Other  
To Whom have you made a report of your accident?  Auto Insurance Co.  Employer  Other  
Name of person contacted: \_\_\_\_\_ Attorney Name (if applicable) \_\_\_\_\_

### NO FAULT INSURANCE

Insurance Co. \_\_\_\_\_  
Address \_\_\_\_\_  
Phone # \_\_\_\_\_ Ext \_\_\_\_\_  
Adjustor \_\_\_\_\_  
Claim# \_\_\_\_\_ Policy# \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Relationship To Patient  Self  Spouse  Child  Other

### WORKERS' COMPENSATION INSURANCE

Insurance Co. \_\_\_\_\_  
Address \_\_\_\_\_  
Phone # \_\_\_\_\_ Ext \_\_\_\_\_  
Adjustor \_\_\_\_\_  
Claim # \_\_\_\_\_  
Employer at time of Accident \_\_\_\_\_  
Employer's Address \_\_\_\_\_

## PATIENT CONDITION

Reason for your visit? \_\_\_\_\_ Where is the pain located? \_\_\_\_\_

When did your symptoms begin? \_\_\_\_\_ What do you think was the cause? \_\_\_\_\_

Rate the severity of the pain on a scale of 0 (no pain) to 10 (excruciating pain) 0 1 2 3 4 5 6 7 8 9 10

Type of pain :  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  Burning  Tingling  Cramping  Stiffness  Swelling

How often do you have this pain? \_\_\_\_\_ Is it constant or does it come and go? \_\_\_\_\_

Does the pain interfere with your  Work  Sleep  Daily Routine  Hobby/Recreation

Have you ever received Chiropractic care? \_\_\_\_\_

## ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will help to uncover the layers of damage, especially to your nervous system, that resulted in poor health. Following your exam, your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

	Yes	No	Patient Comment if answer is Yes	Chiropractor Comments
<input type="checkbox"/>	<input type="checkbox"/>	Did you have a difficult birth?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you ever fall out of bed?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Childhood Sicknesses?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chair pulled out when sat down?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you ever fall down stairs?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you play sports?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you ever have a car accident?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you ever slip and fall?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Surgeries?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Physical Stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental Stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Occupational Stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you have any other traumas?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping posture	<input type="checkbox"/> Side <input type="checkbox"/> Stomach <input type="checkbox"/> Back	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you Smoke?	_____	_____

## HEALTH HISTORY

Who is your Primary Care Physician? \_\_\_\_\_ Are you being seen by other specialists? \_\_\_\_\_

(Female Only) Who is your OB/GYN Physician? \_\_\_\_\_ What treatment have you already received for your condition?

Medications (list) \_\_\_\_\_

Surgery (date) \_\_\_\_\_  Physical Therapy  Chiropractic Care (who) \_\_\_\_\_  Other \_\_\_\_\_  None

Date of Last : Physical Exam \_\_\_\_\_ Spinal X-ray \_\_\_\_\_ MRI, CT, Scan \_\_\_\_\_

**Please Circle if you have had any of these conditions Past or Present**

**AIDS/HIV**

**Alcoholism**

**Allergies**

**Anemia**

**Arthritis**

**Goiter**

**Asthma**

**Bleeding Disorder**

**Breast Lump**

**Cancer**

**Chemical Dependency**

**Depression**

**Diabetes**

**Emphysema**

**Epilepsy**

**Fatigue**

**Fractures**

**Gout**

**Headaches**

**Hepatitis**

**Hernia**

**Herniated Disc**

**High Cholesterol**

**Neck Pain**

**Kidney Disease**

**Liver Disease**

**Migraine**

**Multiple Sclerosis**

**Numbness in Fingers**

**Numbness in Toes**

**Osteoporosis**

**Pacemaker**

**Parkinson's**

**Pins and Needles in arms**

**Pins and Needles in legs**

**Back pain**

**Psychiatric Care**

**Pneumonia**

**Prostrate**

**Rheumatoid Arthritis**

**Stroke**

**Thyroid Problems**

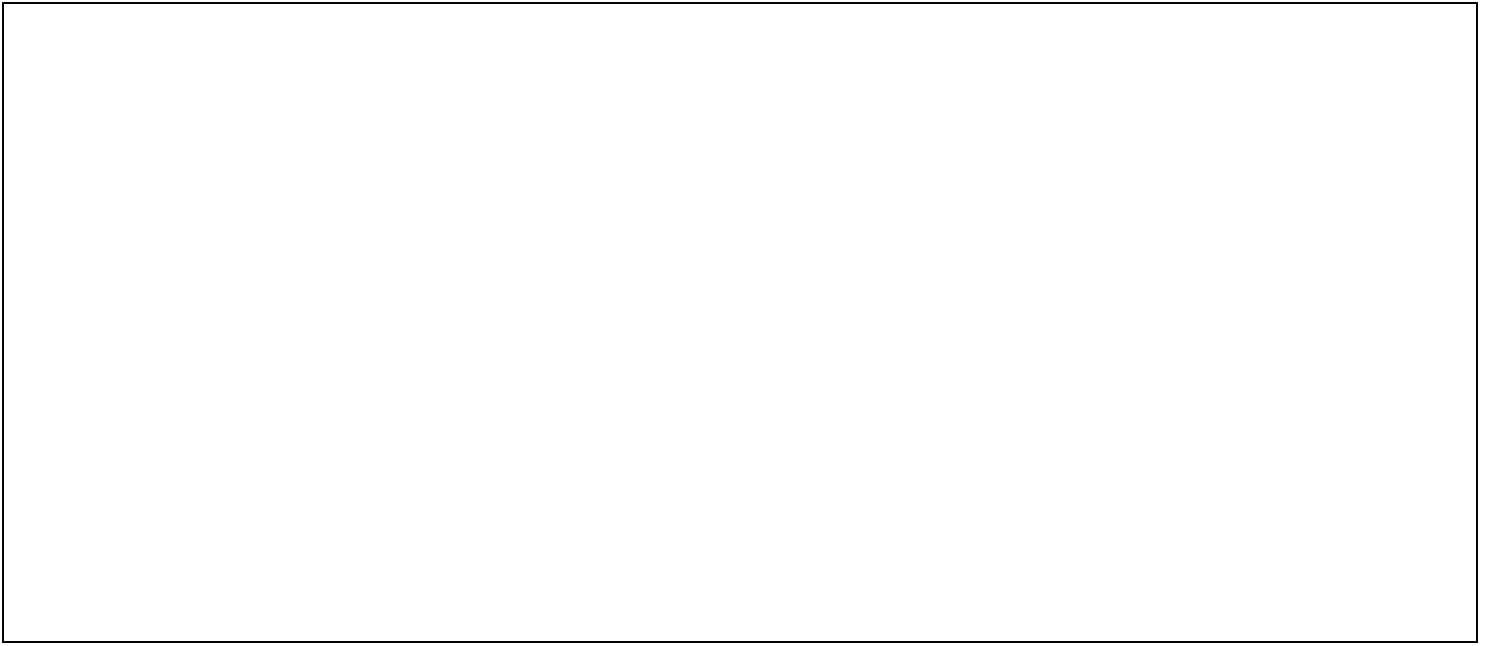
**Tumor/Growth**

**Ulcer's**

**Other \_\_\_\_\_**

\_\_\_\_\_

\_\_\_\_\_



<b>WORKERS' COMPENSATION INSURANCE</b>	



