Date_____

PATIENT INFORMATION

_____
Last Name First Name Middle Initial

Address_____

City _____

State _____ Zip_____ -

Email Address_____

Cell _____

Home_____ Work_____

SSN_____

Date of Birth _____ Age _____ Gender ☐ M ☐ F

Height____ Weight ____ ☐ Married ☐ Widowed ☐ Single

Occupation/Employer_____

Employer Address_____

In case of emergency please contact _____

Relationship_____ Phone _____

INSURANCE INFORMATION

Primary Insurance Company _____

Subscriber's Name_____

Relationship to Patient _____

Subscriber's Employer _____

Employer Address _____

Member # _____

Group # _____

Subscriber's DOB_____

Secondary Insurance Company_____

Subscriber's Name_____

Relationship to Patient _____

Subscriber's Employer _____

Employer Address _____

Employer Phone Number _____

Member # _____

Group # _____

Subscriber's DOB_____

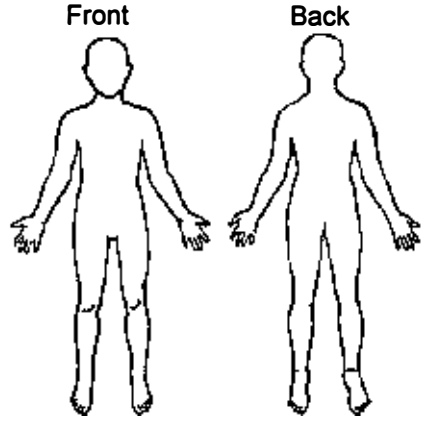
PATIENT CONDITION

Primary health complaint?_____

When did your symptoms appear? _____

Are these symptoms progressively worse? ☐ Yes ☐ No

Mark an **X** on the picture where you are having symptoms.



Type of Symptoms: ☐ Sharp Pain ☐ Dull Pain ☐ Throbbing Pain

☐ Numbness ☐ Burning ☐ Tingling ☐ Aching

☐ Cramping ☐ Stiffness ☐ Swelling

How often do you have this pain? _____

Is the pain constant or does it come and go? _____

Does the pain interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other

Activities that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Bending

ACCIDENT INFORMATION

Are any of the above conditions due to an accident? ☐ Yes ☐ No (If so) Date_____ State_____

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other

Signature _____ Date_____

HEALTH HISTORY

Patient Name _____ **Date**_____

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other_____

Name of the doctor(s) who has (have) treated you for your condition: _____

Date of Last: Physical Exam _____ Spinal Exam _____ Spinal X-Ray _____ Chest X-Ray _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____ Blood Test _____ Urine Test _____

Please check "Yes" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	Edema	☐ Yes	Hyperglycemia	☐ Yes	Polio	☐ Yes
Alcoholism	☐ Yes	Emphysema	☐ Yes	Hypoglycemia	☐ Yes	Prostate Cancer	☐ Yes
Allergy Shots	☐ Yes	Epilepsy	☐ Yes	Ischemia	☐ Yes	Prostate Enlargement	☐ Yes
Anemia	☐ Yes	Exercise – Arm Pain	☐ Yes	Kidney Disease	☐ Yes	Prosthesis	☐ Yes
Appendicitis	☐ Yes	Exercise – Leg Pain	☐ Yes	Kidney Stones	☐ Yes	Psychiatric Care	☐ Yes
Arthritis (Osteo)	☐ Yes	Fractures	☐ Yes	Liver Disease	☐ Yes	Rheumatic Fever	☐ Yes
Arthritis (Rheumatoid)	☐ Yes	Gall Stones	☐ Yes	Measles	☐ Yes	Shortness Breath	☐ Yes
Asthma	☐ Yes	Glaucoma	☐ Yes	Menopause	☐ Yes	Skin Disorders	☐ Yes
Auto Immune Disorder	☐ Yes	Goiter	☐ Yes	Migraines	☐ Yes	STD	☐ Yes
Bleeding Disorder	☐ Yes	Gout	☐ Yes	Miscarriage	☐ Yes	Stroke	☐ Yes
Blood Clot	☐ Yes	Headaches	☐ Yes	Mononucleosis	☐ Yes	Suicide Attempt	☐ Yes
Breast Lump	☐ Yes	Heart Disease	☐ Yes	Multiple Sclerosis	☐ Yes	Thyroid Problem	☐ Yes
Bronchitis	☐ Yes	Hepatitis	☐ Yes	Mumps	☐ Yes	Tonsillitis	☐ Yes
Cancer	☐ Yes	Hernia	☐ Yes	Murmur/Palpitation	☐ Yes	Tuberculosis	☐ Yes
Cataracts	☐ Yes	Herniated Disk	☐ Yes	Osteoporosis	☐ Yes	Tumors	☐ Yes
Chemical Dependency	☐ Yes	Herpes	☐ Yes	Parkinson's	☐ Yes	Typhoid Fever	☐ Yes
Chicken Pox	☐ Yes	High Blood Pressure	☐ Yes	Pinched Nerve	☐ Yes	Ulcer	☐ Yes
Eating Disorder	☐ Yes	High Cholesterol	☐ Yes	Pneumonia	☐ Yes	Varicose Veins	☐ Yes
Diabetes (please circle) (Type 1, Type 2)	☐ Yes	History of Extensive Antibiotic Use	☐ Yes	PVD-Peripheral Vascular Disease	☐ Yes	Yeast Infections	☐ Yes
						Other_____	

Are you pregnant? ☐ Yes ☐ No ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester Due Date?_____

Do you have a pacemaker? ☐ Yes ☐ No

Previous Injuries/Surgeries (Include Date):

Falls _____ Head Injuries _____

Surgeries _____ Broken Bones _____

List any medications (prescription or non-prescription), vitamins, or supplements you are currently taking. _____

_____

_____

List any allergies (including food) of which you are aware. Were you tested for these allergies? ☐ Yes ☐ No

_____

Pharmacy Name_____ Pharmacy # (_____)_____

Family Medical History (please include which family member – mother (m), father (f), aunt (a), uncle (u), grandparent (g):

Diabetes _____ Hypoglycemia _____ Food Allergies (please specify) _____ Rheumatoid Arthritis _____ Thyroid _____ Digestive Disorders _____

Heart Disease _____ Hypertension _____ Stroke _____ High Cholesterol _____ Cancer(please specify) _____ Osteoporosis _____ Other _____