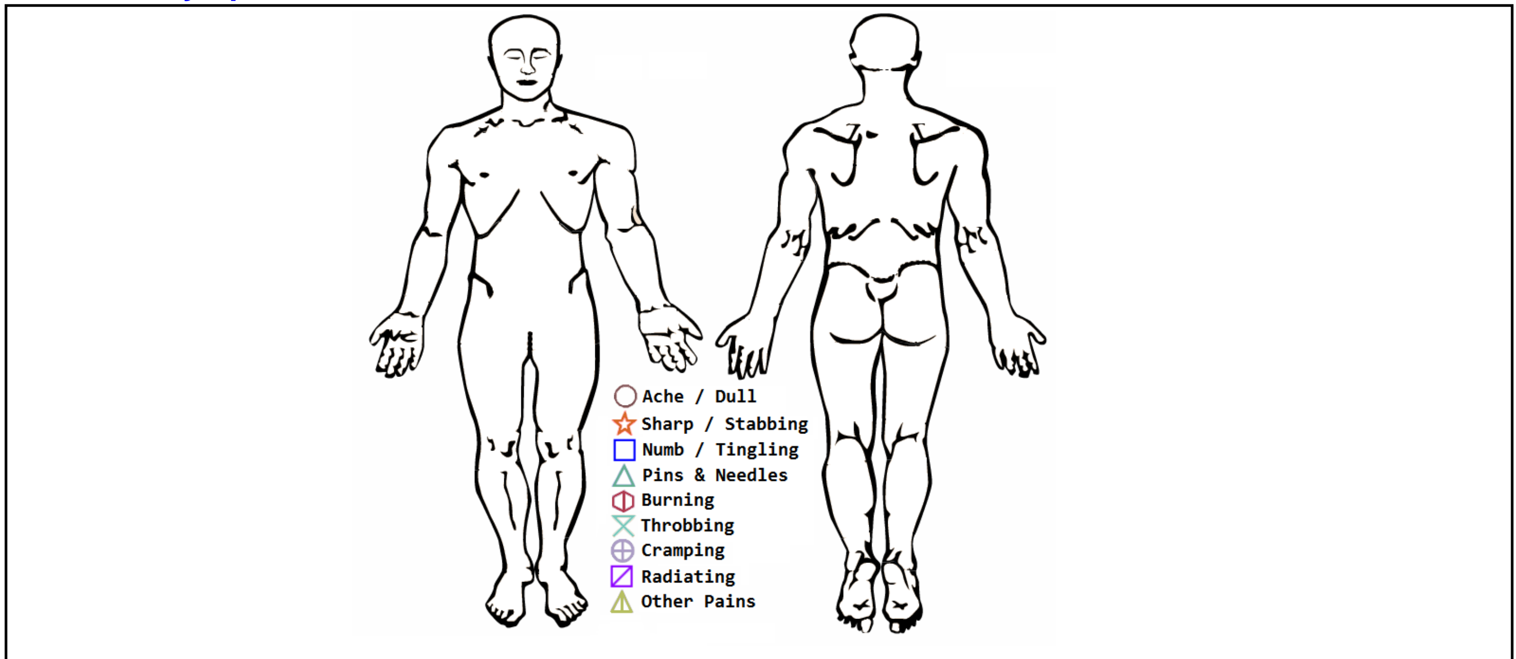
Phone:

Patient Information:

Date			SSN	Birthday
First Name			Middle Name	Last Name
Sex	Male	Female	Height	Weight
Married/Civil Union:			Spouse Name	# of Children
Home #			Cell #	Work #
Address				
City			State	Zip
Emergency Contact			Emergency Relation	Emergency Phone
Email				

Patient Symptoms:



Patient Social

Alcohol:	Daily	Weekly	Occasionaly	Never	Caffeine:	Daily	Weekly	Occasionaly	Never
Diet Food Products:	Daily	Weekly	Occasionaly	Never	Drugs:	Daily	Weekly	Occasionaly	Never
OTC Stimulants:	Daily	Weekly	Occasionaly	Never	Exercise:	Daily	Weekly	Occasionaly	Never
Homemade Food:	Daily	Weekly	Occasionaly	Never	Processed:	Daily	Weekly	Occasionaly	Never
Soft Drinks:	Daily	Weekly	Occasionaly	Never	Tobacco:	Daily	Weekly	Occasionaly	Never
Water:	Daily	Weekly	Occasionaly	Never					

Referral Information:

Referring Physician: Referred Patient: Referred by

Advertisement: Yes No Advertisement:

Referred Directory: Yes No Referred Directory:

Chiropractic Experience:

Who referred you to our office:

Where did you hear about us? Newspaper Sign Yellow Pages Mailing Community Event Other

Have you been adjusted by a chiropractor before? Yes No If yes, Why?

Doctor's Name: Approximate Date of Visit

Employer Information:

Employed: Employer Name

Employer Address:

Employer City: Employer State: Employer Zip:

Occupation: Work Supervisor: Supervisor #:

Work Duties:

Complaint Information:

Injury Occurred: Work Automobile Third-Party Other Injury Date:

Injury Origin:

Desc Discomfort:

Interfere w/ Activities: Yes No Affected Sleep: Yes No Frequency:

Missed Work: Yes No Unable to Work from: Unable to Work Until:

Affected Appetite: Yes No Explain:

Reduced Work: Yes No Explain:

Does it Worsen: Yes No Explain:

Weather Affects it: Yes No Explain:

Aggravates Condition:

Improves Condition:

Received Treatment: Yes No Explain:

X-rays Taken: Yes No Explain:

Same Condition Before: Yes No Date: Practitioner:

For Women Only:

Are you pregnant? Yes No Are you taking birth control? Yes No Do you have irregular cycles? Yes No

Are you nursing? Yes No Do you experience painful periods? Yes No Do you have breast implants? Yes No

Insurance Information:

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 #
Attorney Name	Attorney Phone #	

Personal Health History

Last Physical Exam:	Primary Phys:	Phys Phone #:
Phys City:	Phys State:	Phys Zip:

Health Conditions:

Previous Chiro Care: Yes No Date: Condition(s) treated:

Chance Pregnant: Yes No Planning: Yes No

Medications:

Supplements:

Personal Incident History:

Broken Bones:	Yes	No	Treatment:	Yes	No	Explain
Sprains/Strains:	Yes	No	Treatment:	Yes	No	Explain
Hospitalized:	Yes	No	Explain:			
Surgery:	Yes	No	Explain:			
Auto Accident:	Yes	No	Treatment:	Yes	No	Explain
Struck Unconscious:	Yes	No	Treatment:	Yes	No	Explain
Eating Disorder:	Yes	No	Explain:			
Stroke:	Yes	No	Explain:			

Health Checklist:

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

Family Health History:

Family Health History

EHR Information:

Pefered Language

Smoking Status

Race

Ethinicty

I choose to decline receipt of my clinical summary after every visit

Current Medications And Dosage

Medication Allergies

Signature Date: