Confidential Patient Information

In order for us to understand your health problems, please complete the form below. After review and examination, if we do not sincerely believe your problem will respond favorably to chiropractic care, we will not accept your case. We will refer you to a specialist we believe will help you. Thank you for selecting Chiropractic Professional Center as part of your health care team.

Patient Name______________________________________ **Date**________________________

Age______ **Date of Birth** ________________ **Email address**____________________________

Address______________________________________ **City**__________ **State**____ **Zip** _______

Phone: Home(   )__________________ **Work** (   )_______________ **Cell** (   ) _______________

Occupation______________________________ **Employer** ______________________________

Address of Employer______________________________ **City**__________ **State**_____ **Zip** _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced **Children**: ☐ Yes ☐ No **Ages**:________________

Emergency Contact__________________________ **Relationship**____________ **Phone**(   ) __________

Spouse__________________________________ **Spouse's Occupation** _______________________

Spouse's Employer___________________________ **Business Phone** ___________________________

Whom may we thank for referring you? ____

Present Family Doctor_________________________ **Phone & Address**__________________________

CURRENT PROBLEM OR CONDITION____

When did this problem start? ____
How did it start? ____**Sudden/ Gradual**
Have you ever had similar problems before? ☐ Yes ☐ No **When?** ________________________________

Did you have an accident? ☐ Yes ☐ No **If yes:** ☐Auto Accident ☐ Work-related accident ☐ Other _______________
Have you lost days from work? ☐ Yes ☐ No **If yes, how many days?** ______________________________

What makes it worse? _________________________ **What makes it better?** _________________________

Type of Pain: ☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Shooting ☐ Throbbing ☐ Stabbing ☐ Other_____________
Intensity of Pain: ☐ Mild ☐ Moderate ☐ Strong ☐ Severe **Do you experience shooting pain to any part of your body?** ______
____

Where do you hurt? ____

Is the pain or discomfort: ☐ Constant ☐ Occasional **How frequently does it occur?**
____
How long does it last? ______________________ **Is your condition:** ☐ Getting Better ☐ About the Same ☐ Getting Worst

Do you have increased pain during: ☐ Coughing ☐ Sneezing ☐ Bowel movements ☐ None of these
Any change in the bodily functions? ☐ digestion ☐Vision ☐ Breathing ☐ urination ☐ defecation ☐ Sexual ☐ Other _____

WHAT MEDICATIONS ARE YOU TAKING? ____

Have you seen other doctors seen for this condition? ____

Have you had any treatment, x-rays, MRI, or other tests in your areas of complaint? _______________________
Where and when? ____

PREVIOUS CHIROPRACTIC CARE? ____________________________________**RESULTS** ___________________________
Why do you think chiropractic care could help you? ____

How serious do you perceive your problem to be? ____

What other steps have you taken to solve this problem? ____

What's your theory about why they didn't work? ____

How long do you think it will take to get the results you want? ____

What has your lack of health prevented you from doing or enjoying? ____

Have you ever had any of the following conditions: N (No) Y (Yes)

N Y	N Y	N Y	N Y	N Y
☐ ☐Headaches	☐ ☐Arthritis	☐ ☐High blood pressure	☐ ☐Diabetes	☐ ☐Backache
☐ ☐Neck aches	☐ ☐Neuritis	☐ ☐Heart trouble	☐ ☐Asthma	☐ ☐Sciatica
☐ ☐Dizziness	☐ ☐Numbness	☐ ☐Rheumatic fever	☐ ☐Allergies	☐ ☐Muscle spasm
☐ ☐Visual disturbances	☐ ☐Cancer	☐ ☐Stroke	☐ ☐Anemia	☐ ☐Hernia
☐ ☐Oral contraceptives	☐ ☐Blood thin meds	☐ ☐TIA's(mini strokes)	☐ ☐Digestive disorder	☐ ☐Kidney stones
☐ ☐Migraines	☐ ☐Uterine fibroids	☐ ☐Pace Maker	☐ ☐Arteriosclerosis	☐ ☐Other______________
			☐ ☐High cholesterol	☐ ☐Other_____________

Broken Bones____**Surgeries/Hospital stays** __________________________________

Major accidents or Injuries ____

Women Only: Any chance you could be pregnant?_____Date of last menstrual cycle:__________Date of last Pap Smear ___________
Men Only: Date of last PSA(prostate specific antigen): ____

<u>Your Health Habits</u>: **Do you use vitamin supplements?______Type**____

How much do you drink:

Water________ Coffee/Soda_________
Milk_________ Alcohol/Beer ________

Do you regularly eat:

Red meats____ Sugary foods ____ Fast foods_______ Grains/Beans ______
White meats___ Salty foods ______ Snack foods______ Fruits/Vegetables ___

Do you/ did you ever smoke? ☐Yes ☐No **If yes, how many packs per day?**_____________**For how long?**______________
Do you exercise? What type?____________________________________ **If yes, how frequent?** ___________________________

Your usual sleep position: ☐Back ☐Stomach ☐Right side ☐Left side ☐Toss & turn **How many hours per night?** ___________

What type of pillows do you use?______________________________ **How many?**____
How old is your mattress?__________________________ **Is your mattress:** ☐Firm ☐ Medium ☐Soft ☐Other_______________

Do you use orthotics (customized shoe inserts)? _________________**For how long?** ____________________________________

Please check your occupational duties: ☐Prolong standing ☐ Sitting ☐Bending/twisting ☐Lifting ☐Typing ☐Computer work ☐Driving ☐Writing ☐Physical labor ☐Other___________________________________

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and me, not between my insurance company and this office. I authorize this clinic to release any medical information and to complete any usual and customary reports and forms to assist in collecting from my insurance company. **If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered and any deductible or co-pays that is required**. However, I understand that I am responsible for payment in full at this office. In case my account goes to collection an automatic $36.00 processing fee will be added to my balance. In addition if my balance due is over 90 days a rate of 1.5 % per month will be added to my balance. I also understand that I will be responsible for reasonable attorney's fees or 25% of the total of the attorney's fee, which ever is higher.

HEALTH INSURANCE: ☐**YES** ☐**NO** **COMPANY:**____

Patient's Signature:____ **Date**_____________________________________