Welcome...

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ Female ☐ Male Date of Birth: _____ Email: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Do you prefer to receive calls at: ☐ Cell ☐ Home ☐ Work

Are you: ☐ Married ☐ Divorced ☐ Single ☐ Committed Relationship

Your employer: _____ Occupation: _____

Employer address: _____

City: _____ State: _____ Zip: _____

Spouse or parent's name: _____

Work place: _____ Work Phone: _____

Who referred you to our office: _____

Emergency contact: _____ Relationship: _____ Phone : _____

RESPONSIBLE PARTY

☐ Self ☐ Spouse ☐ Parent / Guardian ☐ Other: _____

Primary Phone: _____ Alternate Phone: _____

INSURANCE INFORMATION

Name of primary InsuranceCo: _____

Insured Party: _____ Relationship to patient: _____

Insured D.O.B. _____ ID #: _____

DETAILS OF YOUR COMPLAINT

Reason for Visit: _____ Date you first notice the symptoms: _____

Did anything contribute to the onset: _____

Where specifically is the problem(s) located: _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Aching
☐ Shooting ☐ Cramp ☐ Tingling Stiffness ☐ Swelling ☐ Other

Is there any radiation of the pain: ☐ Yes ☐ No, if yes where: _____

Is the pain: ☐ Constant ☐ Comes and Goes

Rate the severity of your pain (1 mild pain 10 severe pain): 1 2 3 4 5 6 7 8 9 10

Is this condition getting progressively worse: ☐ Yes ☐ No

Have you found anything that makes the condition worse: ☐ Yes ☐ No

☐ Rest ☐ Morning ☐ Evening ☐ Certain Position ☐ Other: _____

Is this condition getting progressively better: ☐ Yes ☐ No

Have you found anything that makes your condition better: ☐ Yes ☐ No

☐ Rest ☐ Morning ☐ Evening ☐ Certain Position ☐ Other: _____

Have there been any changes in your bodily functions: ☐ Yes ☐ No

☐ Vision ☐ Urination ☐ Sexual ☐ Digestion ☐ Bowel Movement ☐ Respiration

☐ Other: _____

Please Continue On Other Side

Have you sought other professional care for this complaint: ☐ Yes ☐ No

If yes, Dr.'s name and location: _____

Have you ever received chiropractic care: ☐ Yes ☐ No

If Yes, Dr.'s name and location: _____

HEALTH HISTORY:

Check only the conditions that apply:

☐ AIDS/HIV	☐ Digestive disorder	☐ High Cholesterol	☐ Pacemaker
☐ Allergies	☐ Emphysema	☐ High Blood Pressure	☐ Parkinson's Disease
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Pneumonia
☐ Anemia	☐ Fractures	☐ Liver Disease	☐ Prostate Problems
☐ Arthritis	☐ Glaucoma	☐ Measles	☐ Prosthesis
☐ Bleeding disorders	☐ Gout	☐ Migraine/Headaches	☐ Rheumatoid arthritis
☐ Bronchitis	☐ German Measles	☐ Miscarriage	☐ Rheumatic fever
☐ Cancer	☐ Heart Disease	☐ Muscular Dystrophy	☐ Scarlet Fever
☐ Concussion	☐ Hepatitis	☐ Multiple sclerosis	☐ Stroke
☐ Depression	☐ Hernia	☐ Mumps	☐ Sinusitis
☐ Diabetes	☐ Herniated Disc	☐ Osteoporosis	☐ Tuberculosis

Primary Care Doctor: _____ Date of last Physical Exam: _____

List surgeries and dates on which they occurred: _____

List all medications you may currently be taking. _____

Is there a possibility you may be pregnant: _____

DAILY HABITS:

What type of exercise do you perform: ☐ None ☐ Light ☐ Moderate ☐ Heavy

Do you perform this exercise: ☐ Daily ☐ Bi-weekly ☐ 3 x per wk ☐ Other _____

What do your daily work habits include, (sitting, standing, heavy labor, computer work):

_____

_____

Do you smoke: ☐ Yes ☐ No How much per day: _____

How much alcohol do you consume on a weekly basis: _____

How much coffee or caffeinated beverages do you drink on a daily basis: _____

How many hours of sleep do you get per night: 1 2 3 4 5 6 7 8 9 10 11

AUTHORIZATION:

I certify that I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Marysville Chiropractic extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I also acknowledge that there will be fees associated with requests and copying of records at my request. I can obtain a copy of the fee schedule for this process from the office staff at any time. I hereby authorize the doctors of Marysville Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature: _____ Date: _____