PATIENT INFORMATION FORM

Please fill information out in detail for this is important to your case

First name____________________ M.I____ Last Name_______________________ Nickname______________
Address ____ Social Security #______________________
City_________________________________ State_______ Zip_____________________
Age____ Sex____ Birthdate____/____/_____ Marital Status (S, M, W, D)_______ Number of Children______
Home Phone ( )_______________ Cell ( )_________________ Work Phone ( )__________________
Employer_______________________________ Occupation____
Referred by______________________________ Person Responsible for this Account_____________________
Closest Relative__________________________ Address/Phone #____________________________________

What is your main complaint?____

Is this condition due to an: A) auto accident B) work injury C) other accident D) unknown cause

Date symptoms appeared____/____/____

Are symptoms: A) improving B) getting worse C) about the same D) intermittent (come & go)

Have you had these symptoms before? Yes / No If so, when, _____________________________________

Circle any activities that aggravate your condition: A) standing B) walking C) sitting D) lying
E) bending F) lifting G) twisting H) coughing I) Other____

Other doctors seen <u>for this condition</u> A) MD B) Chiropractor C) Osteopath D) Dentist F) Podiatrist
Dr(s). Name______________________ Date Consulted____/____/____ Diagnosis________________________

Have you had surgery? (Y / N) When ____/____/____ and What?____________________________________

Have you had plastic surgery/augmentations? When ____/____/____ and What?____________________

Do you have any significant diseases? (ie. Cancer, Diabetes, etc.)_________________________________

Have you had any broken bones? (Y / N) When ____/____/____ and What?__________________________

Have you been in any accidents? (Y / N) When ____/____/____ and Type?___________________________

Are you taking any medications? (Y / N) What?____

Do you have insurance? (Y / N) Insurance Company____

I understand and agree that the health and accident insurance policies are an arrangement between my insurance carrier and myself, not between the insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete usual and customary reports and forms to assist in collecting from my insurance company. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

Patient's/Guardian's Signature____ Date ____/____/____