# PATIENT INFORMATION FORM

Name: _____ Today's Date: ___/___/___

SSN ☐☐☐☐☐☐☐☐☐ Birth Date: ___/___/___ Age: ___ Gender: __F __M

Phone number: _____ Home/ cell /work Email: _____

Can we text you for appointment reminders? Y N Cell phone provider: _____

Emergency Contact Name/Phone Number: _____

Name of Spouse _____ Spouse's Date of Birth ___/___/___

If you are under 18 years of age, who are your legal parents or guardian?
Father: _____ Date of Birth: ___/___/___ Phone: _____
Mother: _____ Date of Birth: ___/___/___ Phone:_____
Guardian: _____ Date of Birth: ___/___/___ Phone: _____

CURRENT ADDRESS / MAILING
Street _____
City _____ State _____ Zip _____

**Describe your condition, symptoms, or the purpose of this appointment**:_____
_____

**Is your current health complaint directly related to a workplace accident?** (ie. Did you get hurt while at work?)

☐Yes ☐No If **yes**, what was the date of your work injury? _____

If **yes**, have you filed a formal report of your workplace injury with a supervisor? ☐Yes ☐No
If **yes**, Please briefly describe your workplace accident: _____
_____

Have you missed any days of work from your injury ☐Yes ☐No
If **yes**, how many days of work have you missed because of your injury? _____

**Is your condition or injury due to a recent motor vehicle accident?** (Are you here because you were in a car crash?)

☐ YES ☐ NO
If **yes**, what was the date of the car accident? _____

If **yes**, have you filed a claim with YOUR automobile insurance company? ☐ YES ☐ NO
If **yes**, whose car were you in at the time of the accident? (personal, work vehicle, friend's car, etc.)_____

Have you ever had previous Chiropractic Care: __Yes__ No

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.
1. Name: _____ Type of Practice: _____
Date of First Visit: ___/___/___ Date of Last Visit:___/___/___ How many times did you treat with this doctor? _____

Are you still actively treating with this doctor? ☐YES ☐NO Did the treatment help? ☐ YES ☐ NO

2. Name: _____ Type of Practice: _____
Date of First Visit: ___/___/___ Date of Last Visit:___/___/___ How many times did you treat with this doctor?_____

Are you still actively treating with this doctor? ☐YES ☐NO Did the treatment help? ☐ YES ☐ NO

Please list any special tests you've had for this injury or condition (Xrays, MRI, bone scans, etc.)
Special Test: _____ Approx. Date:_____ Where?:_____
Special Test: _____ Approx. Date:_____ Where?:_____
Special Test: _____ Approx. Date:_____ Where?:_____

What is the name of your primary care physician? _____
Primary care doctors location:_____ Phone #_____
Last Visit Date (approx.) _____

Have you ever been diagnosed by a doctor with the following conditions?
Bulging Discs: Yes No
Herniated Discs: Yes No
Arthritis in your spine: Yes No
Degenerated Discs: Yes No

Please list all **Medications** you are taking:

| ***Medication Name*** | ***Strength (mg)*** | ***Dosage*** |
|---|---|---|
| **Example: Liptor** | **50mg** | **1 tab per day** |
| | | |
| | | |
| | | |
| | | |
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| | | |

Please use back of form if more space is required.

Please list all **Allergies** you have:

| ***Allergy*** | ***Reaction*** | ***Severity(mild/moderate/severe)*** |
|---|---|---|
| **Example: Penicillin** | **hives** | **mild** |
| | | |
| | | |

Please list all **Surgeries** that you have had:

| ***Date (Approx.)*** | ***Surgery*** |
|---|---|
| **January 2005** | **Example: Right knee replacement** |
| | |
| | |
| | |

Please list all **Hospitalizations** that you've had:

| ***Date (Approx.)*** | ***Reason*** | ***Hospital*** |
|---|---|---|
| **Example: July 2004** | **Pneumonia** | **Pocono Medical Center** |
| | | |
| | | |
| | | |

Please list all **Major Injuries/Illness** that you've had:

| ***Date (Approx.)*** | ***Injury/Illness*** |
|---|---|
| **Example: July 2004** | **Motor cycle accident/ Ovarian Cancer** |
| | |
| | |
| | |

**Family History (please circle)**

Mother: Living / Deceased Cancer / Diabetes / Heart Disease / Stroke Other:_____

Father: Living / Deceased Cancer / Diabetes / Heart Disease / Stroke Other:_____

**Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

**Smoking Status:** ☐Never smoker ☐Current every day smoker ☐Current some day smoker ☐Former smoker

**Alcohol Status:** ☐ No consumption ☐ Casual consumption ☐ Moderate consumption ☐ Heavy consumption

**Illicit drug use:** ☐ None ☐ Former illicit drug use ☐ Current illicit drug use

**Exercise:** ☐ Never ☐ Daily ☐ Weekly

**Occupational History**

| ***Start date (Approx.)*** | ***End Date(Approx.)*** | ***Occupation*** |
|---|---|---|
| **Ex. July 2005** | **May 2014** | **Machinist/Student/Legal Secretary** |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**INSURANCE INFORMATION**

Do you have personal health insurance? ☐ YES ☐ NO Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/_____

Does the policy holder have the insurance through his/her employer? ☐ YES ☐ NO
If yes, who is the employer? _____
If this is due to an active workman's compensation injury:
Name of work HR supervisor_____
Phone Number (____ )_____
Name of Insurance Company_____
Phone Number (___ )_____
Policy #_____
Adjuster Name _____

**INSURANCE BENEFIT VERIFICATION**

Would you like us to do a one-time review your reported insurance benefits with you before any care is rendered today? (check one)

☐ Yes
☐ No

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# REVIEW OF SYSTEMS

In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

**Const. (Health in General) ❑ No Problems**

Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____

**Ears, Nose, Mouth & Throat ❑No Problems**

Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

**C-V (Heart & Blood Vessels) ❑ No Problems**

Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking.
Other: _____

**Resp. (Lungs & Breathing) ❑ No Problems**

Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

**GI (Stomach & Intestines) ❑ No Problems**

Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

**GU (Kidney & Bladder) ❑ No Problems**

Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence.
Other: _____

**MS (Muscles, Bones, Joints) ❑ No Problems**

Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain.
Other: _____

**Integumentary (Skin, Hair & Breast) ❑ No Problems**

Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes.
Other: _____

**Neurologic (Brain & Nerves) ❑ No Problems**

Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

**Psychiatric (Mood & Thinking) ❑ No Problems**

Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions.
Other: _____

**Endocrinologic (Glands) ❑ No Problems**

Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive.
Other: _____

**Hematologic (Blood/Lymph) ❑ No Problems**

Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas.
Other: _____

**Allergic/Immunologic ❑ No Problems**

Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV.
Other: _____

Signature Patient: _____ Date: _____