PATIENT INFORMATION FORM

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

Social Security Number ☐☐☐☐☐☐☐☐☐ Birth Date: ___/___/___ Age: ____ Gender: F M

Phone number: _____Home/ cell /work Email:_____

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 / Foster Parent: _____ Date of Birth: ___/___/___ Phone: (_____) _____

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Phone (_____) _____

OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street _____

City _____ State _____ Zip _____

Phone (_____) _____

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.)_____

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

_____

Please describe the onset of your condition (How did the symptoms start?):

_____

Have you ever had the same or similar condition? ☐ YES ☐ NO If yes, when and describe: ____

____

Have you ever had previous Chiropractic Care: ___ Yes ___No How did you respond to previous Chiropractic Care?____________________

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

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

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

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

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:

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

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:

Did your **Father** suffer from any of the following?: ☐Cancer ☐Diabetes ☐Heart disease ☐ Stroke ☐None ☐ Other:_____

Did your **Mother** suffer from any of the following?: ☐Cancer ☐Diabetes ☐Heart disease ☐Stroke ☐None ☐ Other:_____

Social History:

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

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

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

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

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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 _____

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/____