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 favorable 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's Name ____________________ **Date** ____________

Age _______ **Date of Birth** ______________ **Email address** ____________________

Address ____________________ **City** ____________ **State** _____ **Zip** ________

Phone: Home (______) ____________ **Work** (______) ____________ **Cell** (______) ____________

Occupation ____________________ **Employer** ____________________

If retired, when did you retire and what was your main line of work? ____________________

Address of Employer ____________________ **City** ____________ **State** ____ **Zip** _________

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

Emergency Contact ____________________ **Relation** ____________ **Phone** (______) ____________

Spouse ____________________ **Spouse's Occupation** ____________________

Spouse's Employer ____________________ **Business Phone** (______) ____________

Present Family Doctor ____________________ **Phone & Address** ____________________

____

WHAT IS YOUR CURRENT PROBLEM OR CONDITION? ____________________

____

When did this problem start? ____________________

How did it start? ____________________

Have you ever had similar problems before? ☐ Yes ☐ No **If yes, when?** ________ **If yes was it Sudden or Gradual?**

Did you have an accident? ☐ Yes ☐ No **If yes:** ☐ Auto Accident ☐ Work-related accident ☐ Fall ☐ 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 parts of your body?**

Yes /No If yes, where?____________________

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 daily functions? ☐Digestion ☐Vision ☐Breathing ☐Urination ☐Defecation ☐Sexual ☐Other ______

WHAT MEDICATIONS ARE YOU TAKING? ____________________

____

Have you seen other doctors for this condition? ____________________

Have you had any treatments, x-rays, MRI, or other test in your areas of complaint? ☐ Yes ☐ No

If yes, where and when? ____________________

Do you have any previous chiropractic care? ☐Yes ☐No

If yes, what were the results? ____________________

Why do you think chiropractic care could help you? ____________________

How serious do you perceive your problem? ____________________

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

What is your theory about why the steps did not work? ____________________

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

(OVER)

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

Do you currently, or have you ever had in the past, any of the following conditions, or have taken the medication:
Please write N (NO) or Y (YES), and please write the date it started/ occurred, next to it, if YES.

Y/N	Y/N	Y/N	Y/N
___ Headaches	___ Numbness	___ TIA's (mini strokes)	___ Backache
___ Neck aches	___Blood thin meds	___ Pace maker	___ Sciatica
___ Dizziness	___ Uterine fibroids	___ Diabetes	___ Muscle spasm
___ Visual disturbances	___ High blood pressure	___ Asthma	___ Hernias
___ Used Oral contraceptives	___ Heart trouble	___ Allergies	___ Kidney stones
___ Migraines	___ Rheumatic fever	___ Anemia	___ Gall stones
___ Arthritis	___ Stroke	___ Digestive disorders	___ HIV
___ Fibromyalgia	___ Arterial Disease	___ High cholesterol	___ Cancer
___ Neuritis	___ Venous Disease	___ Depression	___ Autoimmune Disease

Family Medical History: Cancer, Diabetes, ↑Cholesterol, Stroke, Heart attack, Autoimmune___________________

Other conditions: ____

Broken Bones ___________________________________**History of Head Trauma:**______________________________

Surgeries/ Hospital stays ____

Major accidents or Injuries ____

Date and location of your last blood work and or urinalysis: ____

____

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): _______________ Date of last prostate exam:_______________

YOUR HEALTH HABITS: Do you take vitamin supplements? □Yes □No **Type:** __________________________________

How much do you drink?
Water ___ Coffee/Soda ___
Milk ___ Alcohol/Beer ___

How regularly, do you eat?
Red meat ___ Sugary foods ___ Sea food__ Fast food ___ Grains/Beans _____
White meats ___ Salty foods ___ Snack foods ___ Fruits/Vegetables _________

Do/ did you ever smoke? □Yes □No **If yes, how many packs per day?** ___________ **If yes, for how long?** ________

Do you exercise? □Yes □No **If yes, what type?** ____________________ **If yes, how frequently?** __________________

What is your usual sleep position? □Back □Stomach □Right side □Left side □Toss/turn

How many hours per night do you sleep? ____

What type of pillow do you use? ______________________________ **How many pillows do you use?** _______________

How old is your mattress? _______________ **Is your mattress:** □Firm □Medium □Soft □Other __________________

Do you use Orthotics (customized shoe inserts)? □Yes □No **If yes, for how long?** ______________________________

Please check you occupational duties: □Prolong standing □ Prolong 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 my condition is a regular health insurance case, then I agree to pay a percentage of services as they are rendered and any deductible or co-payments that are 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. **I also agree not to raise the Statue of Limitation as a defense**. 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 the attorney's fees in the amount of 15% of the balance due.

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

PATIENT'S SIGNATURE: ____**DATE:** ___________**DR.'S INITIALS:** ________

(OVER)