

Today's Date _____

Acct. # _____

PATIENT INTRODUCTION

Please fill out both pages completely, print out, and bring to your appointment.

Name _____ Married Single Widowed Other
Last First Middle

Social Security # _____ Date of Birth ____/____/____ Age _____ Mr. Mrs. Ms.
 Miss Dr. Rev.

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

E-mail Address: _____

Insurance Company Name _____

Employer _____ Occupation _____

Work Address _____

Spouse's Name _____ SS# _____ Date of Birth ____/____/____

Who referred you to us? _____

LIST PRESENT COMPLAINTS:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Name of doctor/ last physical exam date

Name of doctor last seen/date seen/reason

Have you had Chiropractic care before? Yes No

Is it possible you are pregnant? Yes No

Reason for care: Auto Accident On the job injury Other: _____
(Explain)

Date of injury: ____/____/____

Do you have an Attorney due to injury? Yes No Attorney Name _____

Please list all accidents, falls, broken bones, injuries, surgeries, and major illnesses.

| <i>TYPE</i> | <i>DATE</i> | <i>DESCRIBE/COMMENTS</i> |
|-------------|-------------|--------------------------|
|-------------|-------------|--------------------------|

LIST ALL MEDICATIONS CURRENTLY BEING TAKEN

PLEASE PRESENT A COPY OF INSURANCE CARD & DRIVERS LICENSE

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | |
|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema |

INTAKE

- Coffee
 Tea
 Alcohol
 Cigarettes
 White Sugar

Have you been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD:

MUSCULO-SKELETAL CODE

- Low Back Pain
 Pain Between Shoulders
 Neck Pain
 Arm Pain
 Joint Pain/Stiffness
 Walking Problems
 Difficult Chewing/Clicking Jaw
 General Stiffness

- Gas/Bloating After Meals
 Heartburn
 Black/Bloody Stool
 Colitis

GENITO-URINARY CODE

- Bladder Trouble
 Painful/Excessive Urination
 Discolored Urine

NERVOUS SYSTEM CODE

- Nervous
 Numbness
 Paralysis
 Dizziness
 Forgetfulness
 Confusion/Depression
 Fainting
 Convulsions
 Cold/Tingling Extremities
 Stress

C-V-R CODE

- Chest Pain
 Short Breath
 Blood Pressure Problems
 Irregular Heartbeat
 Heart Problems
 Lung Problems/Congestion
 Varicose Veins
 Ankle Swelling
 Stroke

GENERAL CODE

- Fatigue
 Allergies
 Loss of Sleep
 Fever
 Headaches

EENT CODE

- Vision Problems
 Dental Problems
 Sore Throat
 Ear Aches
 Hearing Difficulty
 Stuffed Nose

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
 Excessive Thirst
 Frequent Nausea
 Vomiting
 Diarrhea
 Constipation
 Hemorrhoids
 Liver Problems
 Gall Bladder Problems
 Weight Trouble
 Abdominal Cramps

MALE/FEMALE CODE

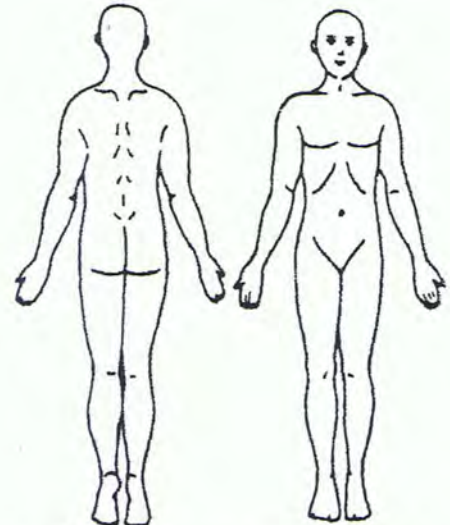
- Menstrual Irregularity
 Menstrual Cramps
 Vaginal Pain/Infection
 Breast Pain/Lumps
 Prostate/Sexual Dysfunction
 Other Problems

FEMALES ONLY:

When was your last period? _____

Are you pregnant?

- Yes No Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

- Mother
 Father
 Brother
 Sister
 Spouse
 Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: Yes No Referred

Doctor's Signature _____