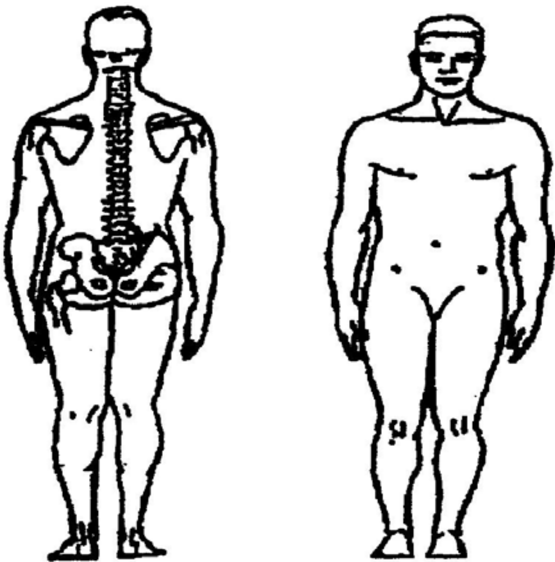
INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. **PLEASE PRINT.**

Name____ Today's Date___________________
Address____ City_______________ State_______ Zip__________
Age_______ Birthday____________________ Marital Status: S M W D Number of Children_______
Home Phone ______________Work Phone_______________ Cell______________ Email______________________

Your Employer___________________________ Occupation_________________________ Years on Job_________
Employer Address___________________________________ City________________ State_______ Zip_________
Insurance Company______________________________ Insurance ID#______________________________
Social Security #__________________________________ Do you have Medicare? Yes_____ No______
In Case of Emergency Who Should We Contact_______________________________ Phone #__________________
Primary Medical Doctor Name___________________________ Phone # ________________________
Address____ City_________________ State_______ Zip__________
Can we contact them to coordinate care if needed? Yes____ No____



← ← ←COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc………..

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MAJOR COMPLAINTS

Please list any other conditions you are being treated for or are experiencing.

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Referred to our office by:______________________________

Is your condition due to an accident? Yes____ No____ Date of accident______________
Type of accident? Auto_____ Work/On Job_____ At Home_____ Other_______________________________
Have you ever been in an auto accident? Past Year_____ Past 5 Years_____ Over 5 Years_____ Never_____
Is your Auto Insurance Policy or Work Comp Insurance covering your care? Yes_____ No_____

Patient's Signature________________________________ Date_______________________
Or Guardian Signature_____________________________ Date_______________________

CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name____ Date________________________

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

Muscle & Joint
- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Poor posture
- Sciatica
- Scoliosis
- Swollen joints

Pain or numbness in:
- Head
- Neck
- Mid back
- Low back
- Shoulders
- Arms
- Elbows
- Wrist
- Hands
- Hips
- Legs
- Knees
- Ankle
- Feet

General
- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Depression
- Numbness
- Sweats
- Tremors

Cardio-Vascular
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Abnormal heart beat
- Swelling of ankles

Gastro-Intestinal
- Belching or gas
- Colitis
- Constipation
- Diarrhea
- Difficult digestion
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

Respiratory
- Chest pain
- Chronic cough
- Difficulty breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

Eyes, Ears, Nose & Throat
- Asthma
- Colds
- Deafness
- Earache
- Ear Noises
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Recent vision changes
- Hoarsness
- Nosebleeds
- Sinus infection
- Sore throat
- Tonsillitis

Skin
- Boils
- Bruse easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions(rash)
- Varicose veins

Genito-Urinary
- Bed-wetting
- Blood in urine
- Frequent urination
- Kidney infection
- Painful urination
- Prostate trouble

For Women Only
- Painful breasts
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge

Are you pregnant? Yes No

CHECK ANY OF THE FOLLOWING CONDITONS YOU MAY HAVE HAD

Alcoholism	Arthritis	Eczema	Goiter	Multiple Sclerosis	Polio	Tuberculosis
Anemia	Cancer	Emphysema	Heart Disease	Pleurisy	Rheumatic Fever	Ulcers
Arteriosclerosis	Diabetes	Epilepsy	Miscarriage	Pneumonia	Stroke	Venereal disease

List surgical operations and years:

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List any medications you take:

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Have you ever:	Yes	No
Been knocked unconscious?		
Been treated for a spine or nerve disorder?		
Had a fractured bone?		
Been hospitalized for anything other than surgery?		
Suffered from a mental or emotional disorder?		
Do you:		
Now take vitamins or minerals?		
Think you need vitamins or minerals?		

Habits	Heavy	Moderate	Light	None
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				

	Excellent	Good	Poor
Sleep			
Diet			

Age of Mattress______________

Comfortable Uncomfortable

Patient's Signature____________________________ Date____________________

Or Guardian Signature____________________________ Date____________________