CONFIDENTIAL PATIENT INFORMATION

Date _____

Cell Phone _____

Name _____ Soc. Sec. #_____ Home Phone _____

Address _____ City_____ ZipCode _____

Age _____ Birth Date _____ Marital: M S W D How many children _____

Occupation _____ Employer _____

Employer's Address _____ Office Phone _____

YOUR EMAIL ADDRESS: _____@_____

YOUR ALTERNATE ADDRESS (North) _____

_____ **Phone** _____

Name of Wife/Husband _____ Cell Phone # _____

Patient's Nearest Relative (son/daughter)_____Phone Number _____

Referred to our office by _____

Primary Physician's Name _____ **Address** _____

Do you smoke: _____ Yes _____ No _____ Previously How long ago did you stop smoking? _____

Is your present condition due to your employment? _____

Is your present condition due to an automobile accident? _____ Date of Accident _____

Have you ever had a similar condition? _____ If yes, when? _____

Have you lost any days from work?_____ Female: Are you pregnant? _____

What operations have you had? _____ Serious illnesses _____

Have you been under Chiropractic care in the past? _____ Name of Doctor _____

(Please circle all that apply) Circle M for Mother Circle F for Father Circle S for Self

Allergy	M	F	S	Poor Posture	M	F	S	Tuberculosis	M	F	S	Itching	M	F	S
Dizziness	M	F	S	Sciatica	M	F	S	Bruise Easily	M	F	S	Varicose veins	M	F	S
Fatigue	M	F	S	Spinal Curvature	M	F	S	Hay Fever	M	F	S	Bed Wetting	M	F	S
Headache	M	F	S	Swollen Joints	M	F	S	Nose Bleeds	M	F	S	Frequent Urination	M	F	S
Loss of Sleep	M	F	S	Colon Trouble	M	F	S	Sinus Infection	M	F	S	Kidney Infection or Stone	M	F	S
Ulcers	M	F	S	Diarrhea	M	F	S	High Blood Pressure	M	F	S	Prostate Trouble	M	F	S
Nervousness/Depression	M	F	S	Difficult Digestion	M	F	S	Low Blood Pressure	M	F	S	Cramps or Backache	M	F	S
Numbness	M	F	S	Hemorrhoids	M	F	S	Pain Over Heart	M	F	S	Excessive Menstrual Flow	M	F	S
Arthritis	M	F	S	Nausea	M	F	S	Poor Circulation	M	F	S	Hot Flashes	M	F	S
Bursitis	M	F	S	Asthma	M	F	S	Rapid Heartbeat	M	F	S	Irregular Cycle	M	F	S
Foot Trouble	M	F	S	Colds	M	F	S	Slow Heartbeat	M	F	S	Lumps in Breast	M	F	S
Low Back Pain	M	F	S	Deafness	M	F	S	Anemia	M	F	S	Alcoholism	M	F	S
Neck Pain or Stiffness	M	F	S	Ear Noises	M	F	S	Stroke	M	F	S	Diabetes	M	F	S
				Enlarged Thyroid	M	F	S	Chest Pain	M	F	S	Polio	M	F	S
Tingling or Numbness in:				Eye Pain	M	F	S	Difficulty Breathing	M	F	S	Swelling of Ankles	M	F	S
Shoulders	Hips			Failing Vision	M	F	S	Pleurisy	M	F	S	Cancer	M	F	S
Arms	Legs			Venereal Disease	M	F	S								
Elbows	Knees														
Hands	Feet														
Fingers															

PLEASE TURN THIS SHEET OVER

PURPOSE OF THIS VISIT (Major Complaint): _____

_____

What activities aggravate your condition? _____

Is your condition getting progressively worse? Yes No Constant Comes and Goes

Is your condition interfering with your: Employment Sleep Daily Routine Other _____

How long has it been since you felt really well? _____

Other Doctors you have seen for your condition: _____

Have you been treated for any condition in the past year?_____

Describe the condition: _____

What medications or supplements are you currently taking? _____

Who prescribed these medicines? _____

Allergies: _____

Height: _____ **Weight**: _____ **Blood Pressure:** _____

Is there anything else you want us to know about you? _____

_____

PAYMENT IS EXPECTED AT TIME OF VISIT

HOW WILL YOU BE PAYING FOR TODAY'S VISIT? _____ CASH _____ CREDIT CARD _____ CHECK

_____ INSURANCE Are you insured? _____ Name of Insurance Company _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making the collections from the insurance company and that any amount authorized is to be paid directly to Incledon Chiropractic and will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. SHOULD I BE REIMBURSED DIRECTLY FROM MY INSURANCE COMPANY, I AGREE TO PRESENT THE EXPLANATION OF BENEFITS AND CHECK TO INCLEDON CHIROPRACTIC UPON RECEIPT.

PATIENT'S SIGNATURE _____ **Date** _____

GUARDIAN'S OR SPOUSE'S SIGNATURE AUTHORIZING CARE _____ **Date** _____

COMMENTS: _____

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