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		___ Sciatica
___ Dizziness	___ Uterine fibroids	___ Pace maker	___ Muscle spasm
___ Visual disturbances	___ High blood pressure	___ Diabetes	___ Hernias
___ Used Oral contraceptives	___ Heart trouble	___ Asthma	___ Kidney stones
		___ Allergies	___ Gall stones
___ Migraines	___ Rheumatic fever	___ Anemia	___ HIV
___ Arthritis	___ Stroke	___ Digestive disorders	___ Cancer
___ Fibromyalgia	___ Arterial Disease	___ High cholesterol	___ Autoimmune Disease
___ Neuritis	___ Venous Disease	___ Depression	

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 _____

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): _____

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: _____

DOCTOR'S INITIALS: _____

(OVER)