CORE CHIROPRACTIC

Patient Data

Title: __ Mr. __ Mrs. __ Ms __ Miss (check one) **Date:** _____

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address Line 1: _____

Address Line 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____) _____-_____ **Work Phone:** (_____) _____-_____

Cell Phone: (_____) _____-_____

Date of Birth: _____/_____/_____ **Sex:** __Male __Female **Email:** _____

Social Security Number: _____-_____-_____ **Marital Status:** __ Single __ Married __ Other

Employment Status: __ Employed __ Full Time Student __ Part Time Student __ Other (check one)

Spouse Data

Is your spouse a patient in the clinic? __ Yes __ No

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Home Phone: (_____) _____-_____ **Work Phone:** (_____) _____-_____

Employer Data

Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact

Contact Name: _____

Contact Phone: (_____) _____-_____

Insurance Information _____

Who is responsible for this account? _____ **Relation to patient** _____

Insurance Co _____ **Group#**_____

Is patient covered by additional insurance? __ Yes __ No **Subscriber's Name** _____

Birth Date _____ **SS#**_____ **Relationship to Patient** _____

Insurance Co _____ **Group#** _____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with (Name of Insurance Company(ies) _____ and assign directly to Dr. _____ all insurance benefits if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance situations. The above named doctor may use my health care information and may disclose such information to the above name insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefit payable for related services. This consent will end when my current treatment plan has completed or one year from the date signed above.

Signature of Patient, Parent, Guardian or Personal Representative _____

How did you hear about our clinic? Or who referred you?

___ Family member	___ Attorney	___ Internet web site	___ Health class
___ Friend	___ Yellow Pages	___ Billboard	___ Brochure
___ Physician	___ Newspaper ad	___ TV Commercial	___ Direct mail ad
___ Employer	___ Sign on building	___ Radio	___ Other

If you selected 'Yellow Pages' please indicate which Yellow Pages:

_____

If you selected 'family member', 'friend', or 'physician' please enter their name below:

_____

If you selected 'other' please describe

_____

Medical Conditions:

___ Arthritis	___ Cancer	___ Diabetes	___ Heart Disease
___ Hypertension	___ Psychiatric Illness	___ Skin Disorder	___ Stroke

Surgeries:

___ Appendectomy	___ Cardiovascular procedure	___ Cervical disc procedure	___ Hysterectomy
___ Joint replacement	___ Laminectomies	___ Radical prostatectomy	___ Transuretheral prostate surgery

Allergies:

___ Eggs	___ Fish and Shellfish	___ Milk or Lactose	___ Peanut
___ Soy	___ Sulfites	___ Wheat/Gluten	

Social History:

___ Caffeine used occasionally	___ Caffeine used often	___ Chew tobacco occasionally	___ Chew tobacco often
___ Drink alcohol occasionally	___ Drink alcohol often	___ Exercise not at all	___ Exercise occasionally
___ Exercise often	___ Experience stress occasionally	___ Experience stress often	___ Smoke 1 pack or less per day
___ Smoke more than 1 pack a day	___ Wear seat belts always	___ Wear seat belts never	___ Wear seatbelts usually

Family History:

___ Arthritis (parent) ___ Arthritis (sibling) ___ Cancer (parent) ___ Cancer (sibling)
___ Cholesterol (parent) ___ Cholesterol (sibling) ___ Diabetes (parent) ___ Diabetes (sibling)
___ Heart problems (parent) ___ Heart problems (sibling) ___ High blood pressure (parent) ___ High blood pressure (sibling)
___ Psychiatric (parent) ___ Psychiatric (sibling) ___ Stroke (parent) ___ Stroke (sibling)
___ Thyroid (parent) ___ Thyroid (sibling)

Substance Use:

___ Alcohol (past) ___ Alcohol (present) ___ Amphetamines (past)` ___ Amphetamines (present)
___ Barbiturates (past) ___ Barbiturates (present) ___ Cocaine (past) ___ Cocaine (present)
___ Crystal Meth (past) ___ Crystal Meth (present) ___ Heroine (past) ___ Heroine (Present)
___ Marijuana (past) ___ Marijuana (present)

Male Children:

Ages/Birthdays _____

Female Children:

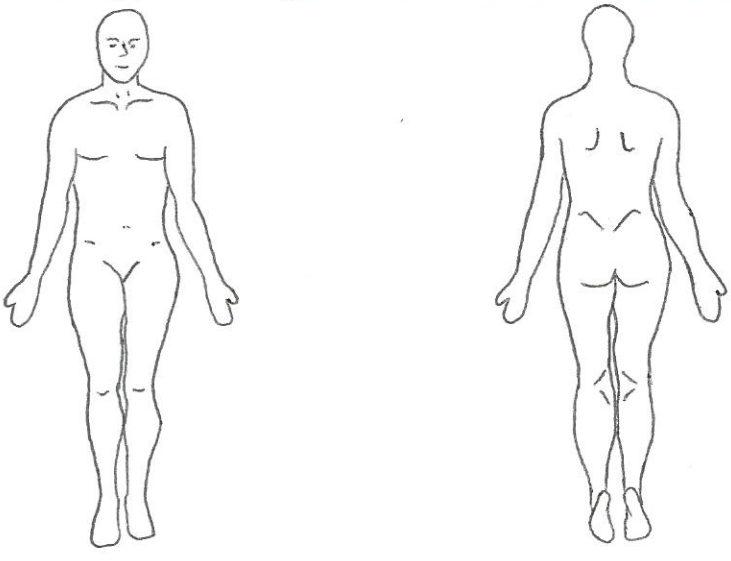
Ages/Birthdays _____

Occupational Activities:

___ Administration ___ Business owner ___ Clerical/secretarial ___ Computer user
___ Construction ___ Daycare/childcare ___ Executive/legal ___ Food service industry
___ Health care ___ Heavy equipment operator ___ Heavy manual labor ___ Home services
___ Household ___ Light manual labor ___ Manufacturing ___ Medium manual labor

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

 # = Numbness X = Burning / = Stabbing 0 = Pins & Needles + = Dull Ache



Describe your symptoms:_____

_____

When did your symptoms start? Month_____ **Day**_____ **Year**_____

Indicate the average intensity of your symptoms? (0 = None to 10 = Unbearable)

___ 0 None ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 Unbearable

How often do you experience your symptoms?

__ Constantly (76-100% of the day) __ Frequently (51-75% of the day) __ Occasionally (26-50% of the day) __ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

__ Sharp __ Dull ache __ Numb __ Shooting
__ Burning __ Tingling __ Stabbing

How are your symptoms changing?

__ Getting better __ Not changing __ Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms? (0 = None to 10 = Unbearable)

__ 0 None __ 1 __ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10 Unbearable

During the past 4 weeks, how much has pain interfered with your normal work? (including both work outside the home and housework)

__ Not at all __ A little bit __ Moderately __ Quite a bit __ Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

__ All of the time __ Most of the time __ Some of the time __ A little of the time __ None of the time

In general, would you say your overall health right now is....

__ Excellent __ Very good __ Good __ Fair __Poor

Who have you seen for your symptoms?

__ No one __ Other Chiropractor __ Medical Doctor __ Physical Therapist _____ Other

What treatment did you receive for your symptoms?

__ Adjustments __ Physical Therapy __ Medication __ Surgery _____ Other

When did you receive this treatment?

__ In the last month __ 2 – 3 months ago __ 3 – 6 months ago __ 6 months to 1 year ago
__ 1 – 2 years ago __ 2 – 5 years ago __ 5 – 10 years ago

What tests have you had for your symptoms?

__ X-rays __ MRI __ CT Scan __ Other

When were these tests done?

__ In the last month __ 2 – 3 months ago __ 3 – 6 months ago __ 6 months to 1 year ago
__ 1 - 2 years ago __ 2 – 5 years ago __ 5 – 10 years ago

Have you had similar symptoms in the past?

___ Yes ___ No

If you have had treatment in the past for the same or similar symptoms, who did you see?

__ This Office __ Other Chiropractor __ Medical Doctor __ Physical Therapist __ Other

What is your occupation?

_____

If you are not retired, a homemaker or a student, what is your work status?

__ Full-time __ Part-time __ Self-employed __ Unemployed
__ Off work _____ Other

Thank you. Please return to the front desk