

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Marital Status (M S D W) Age: _____ Birth Date: ____/____/____

Height: _____ Weight: _____ Sex (F M) Race: _____ Phone (H): _____ (W): _____

Spouse's Name: _____ Children: _____ SOCIAL SECURITY #: _____-____-____

Address (Street, City, State, Zip): _____ Medical Doctor: _____

Email Address: _____ Cell #: _____

Occupation: _____ How Long: _____ Employer: _____

Referred by: _____ Previous Chiropractic Care: _____

ACCIDENTS: Please describe, give date, injuries, broken bones, fractures, treatment

Automobile: _____

Occupational: _____

Recreational: _____

Childhood: _____

Operations/Surgeries (type/date): _____

X-Rays (date, where taken, of what, findings) _____

PRESENT COMPLAINT: _____ How Long?: _____ Is it constant?: _____

How did it occur?: _____ What relieves it?: _____

Please check the symptoms you have noticed:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness/Faintness | <input type="checkbox"/> Eye/Vision Problems | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Neck Pain/Stiff | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Arm/Shoulder Pain | <input type="checkbox"/> Chest/Rib Pain |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Pins/Needles Arms | <input type="checkbox"/> Problems Breathing |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Problems Sleeping | <input type="checkbox"/> Finger Numbness | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Pressure in Head | <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Fatigue/Depression | <input type="checkbox"/> Leg/Hip Pain | <input type="checkbox"/> Bowel Problems |
| <input type="checkbox"/> Ear Ache/Ringing | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins/Needles Toes | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Stress/Tension | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Urination Problems |

Symptoms not listed above: _____

Other doctors seen for this condition: _____

What medications are you taking: _____

Health Questions:

Do you smoke? _____ Drink alcoholic beverages? _____ Eat a well-balanced diet? _____ Sleep 6-8 hours? _____ Exercise Regularly? _____

NO SYMPTOMS

EXTREME SYMPTOMS

1 _____ 10

Place an "X" on the line above to indicate the level of the problem

PLEASE LIST ANY AND ALL INSURANCE COVERAGE WHICH MAY BE APPLICABLE IN THIS CASE:

Primary Insurance Company: _____ Secondary Insurance Company: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

Patient or Guardian's Signature: _____ **Date:** _____

Thank you for choosing *DeWald Chiropractic*