

WELCOME

CONFIDENTIAL PATIENT INFORMATION

Thank you for choosing our practice for your chiropractic needs. Please complete this form and be as specific as possible. If you have any questions or concerns, please do not hesitate to ask for assistance. We would be happy to help.

Please print.

Name: _____

Today's Date: _____

Birth date: _____ M F

File # _____

Home Address: _____

Home Phone: _____

Email: _____

Cell Phone: _____

Employer: _____

Work Phone: _____

Employer address: _____

Marital Status: S M W D

Spouse's Name: _____

Whom may we thank for referring you? _____

When did your symptoms start? _____

How did your symptoms begin? _____

Describe your symptoms _____

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)

How are your symptoms changing?

- Getting Better
- Not changing
- Getting worse

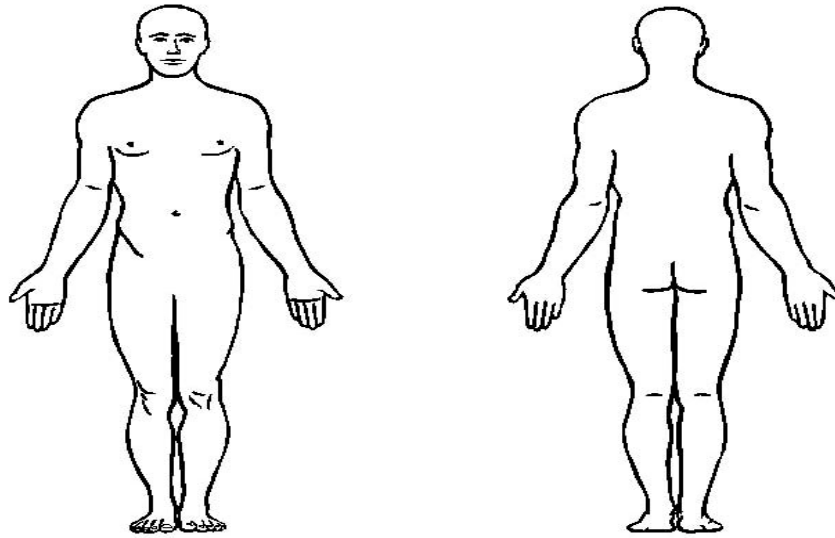
Is this condition interfering with your (please circle): work sleep daily routine

During the past 4 weeks how much of the time has your condition interfered with your lifestyle?

- A little bit
- Moderately
- Quite a bit
- Extremely
- I have been without pain

SHOW US WHERE IT HURTS! PLEASE BE SPECIFIC! Please rate the severity of your pain.

1 2 3 4 5 6 7 8 9 10 (1, mild pain or discomfort, to 10, severe pain)



PRESENT SYMPTOMS

Please circle the symptoms you have noticed due to this condition.

- | | | |
|--------------------------------|----------------|-------------------|
| Headache | Fainting | Sleeping problems |
| Irritability | Numbness | Hip pain |
| Ears Ringing | Chest pain | Radiating pain |
| Tension | Stiffness | Fever |
| Cold Sweats | Pins & Needles | Dizziness |
| Neck Pain | Fatigue | Depression |
| Nervousness | Soreness | Mid back pain |
| Upset stomach | Stabbing pain | Nausea |
| Pain with coughing or sneezing | Back pain | |
| | Burning | |

Other: (please explain)

Have you been treated by a Chiropractor for this condition? Yes No

Have you been treated by a Medical Physician for this condition? Yes No

Where did you receive treatment? _____

When did you receive treatment? _____

What tests were performed for your symptoms? X-rays MRI CT Scan

Other (please explain)

Height _____ Weight _____

HEALTH HISTORY

Have you been treated by a Chiropractor within the last five years?

Prior illness:

Past Hospitalizations:

Surgeries:

Medications:

Vitamins/Supplements:

Have you ever had any of the following medical condition(s)? Please circle.

- | | | |
|-------------------------|-----------------|---------------------|
| Stroke | Thyroid disease | Vertigo |
| Seizure | Arthritis | AIDS/HIV |
| Diabetes | Sinus Problems | Ear Infections |
| Asthma | Prosthesis | PMS |
| Heart Attack | Migraines | Allergies |
| Kidney Problems | Chronic fatigue | High Cholesterol |
| Anemia | Infertility | Parkinson's Disease |
| High/low blood pressure | Irritable Bowel | |

Fractures _____

Cancer _____

ACCOUNT INFORMATION

INSURANCE? YES NO

If you want us to file your claims with your insurance company, please present card at desk.

Who is ultimately responsible for account? _____ Phone: _____

Address: _____

Thank you for entrusting us with your health needs. Choosing a health care provider is not a decision that you made lightly. At our office, we have a simple and to the point concern. Our goal is to offer the highest quality chiropractic care to everyone who seeks our services. We want each and every person who comes to us to feel we have given our all toward getting maximum results. I consider your relationship with us to be a two-way street. We will do half of the work and you will do half the work. I say this because ultimately, you heal you! Through our safe, painless method of adjusting your misaligned bones, we are able to remove nerve irritation. We will be happy to answer any questions concerning your care, chiropractic and health in general. We also have a referral network with various other specialists if the need arises.

I UNDERSTAND AND AGREE THAT CHARGES AT THIS OFFICE ARE AN AGREEMENT BETWEEN MY INSURANCE COMPANY AND MYSELF—NOT BETWEEN MY INSURANCE AND CROWLEY CHIROPRACTIC. I AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT IN FULL AT THIS OFFICE. I AGREE TO PAY THE PERCENTAGE/COPAYS/DEDUCTIBLE AS REQUIRED. I UNDERSTAND IF I DO NOT HAVE INSURANCE, PAYMENT IS DUE AND PAYABLE ON THE DATE OF SERVICE.

Patient Signature: _____

Date: _____

Guardian's Signature Authorizing Care: _____

Date: _____