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 __________________

<u>YOUR EMAIL ADDRESS</u>: ____________________________________@____

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 ____________________________

(<u>Please circle all that apply</u>) 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? ____

____

<u>PAYMENT IS EXPECTED AT TIME OF VISIT</u>

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. <u>SHOULD I BE REIMBURSED DIRECTLY FROM MY INSURANCE COMPANY, I AGREE TO PRESENT THE EXPLANATION OF BENEFITS AND CHECK TO INCLEDON CHIROPRACTIC UPON RECEIPT.</u>

PATIENT'S SIGNATURE ____ **Date** ____________________

GUARDIAN'S OR SPOUSE'S SIGNATURE AUTHORIZING CARE ___________________________ **Date** ____________________

COMMENTS: ____

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