

# PATIENT INTRODUCTION FORM

Today's Date: \_\_\_ / \_\_\_ / \_\_\_

Patient Name:	
Address:	
City/State/Zip:	Home Telephone:
DOB: _____ Age: _____	Work Telephone:
E-mail Address:	Employer Name:
Social Security Number:	Job Title:
Cell Phone Number:	Marital Status (Circle): Single, Married, Divorced, Widowed

Name, Address, Relationship, and Telephone Number of your nearest relative (for emergencies):

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**\*\*\*Please give the receptionist your driver's license, health insurance card and, if needed, auto insurance card to make a copy for our records.**

### INSURANCE INFORMATION

Does your insurance cover Chiropractic Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, indicate Insurance Company Name	Carrier Name: _____ Address: _____
If you are being seen for a work related or car accident injury, we need the Claim Number and the Claim adjusters Name. If unknown, be certain to let the front desk staff know.	Telephone: _____ Claim Number: _____ Claim Adjusters Name: _____
Are you the insured person or dependent?	<input type="checkbox"/> Insured <input type="checkbox"/> Dependent ( Wife/Husband/Child )
If you are the insured persons dependent (spouse or child), we need the insured persons name, date of birth, social security number, and the name of the insured's employers business in order to do billing	Insured's Name: _____ Social Security Number: _____ Insured's Date of Birth: _____ Insurance Company: _____

**\*\*\*Our office will provide insurance billing services for you if you so desire as a courtesy. Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, coinsurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office.**

Law Office representing you: \_\_\_\_\_ Attorney Name: \_\_\_\_\_

Phone # : \_\_\_\_\_ Law Office Address: \_\_\_\_\_

**I authorize the Doctor and staff to perform medical services on me or my child(ren) and know that I am personally responsible for all services rendered.**

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PAST AND PRESENT GENERAL HEALTH HISTORY PAGE 2**

**CHECK RECENT OR CURRENT SYMPTOMS**

<b>SYMPTOM</b>	<b>HOW LONG</b>	<b>SYMPTOM</b>	<b>HOW LONG</b>
<input type="checkbox"/> Headache / Migraines		<input type="checkbox"/> Upper Back Pain, Soreness, Stiffness	
<input type="checkbox"/> Neck Pain, Soreness, Stiffness		<input type="checkbox"/> Hip Pain	
<input type="checkbox"/> Low Back Pain, Soreness, Stiffness		<input type="checkbox"/> Leg or Foot Pain, Numbness, or Tingling	
<input type="checkbox"/> Arm/Hand Pain, Numbness, Tingling		<input type="checkbox"/> Other:	

**SYMPTOM /PAIN DESCRIPTION**

Please circle any word(s) below that best describes how your symptoms currently feel to you.

Pain	Pinching	Spreading	Vicious	Unbearable
Acne	Pricking	Shooting	Sickening	Soreness
Cutting	Tingling	Stabbing	Miserable	Pins and Needles
Tearing	Gnawing	Dull	Troublesome	Radiating
Crushing	Nagging	Bony	Pressing	Weakness
Pulling	Boring	Terrifying	Deep Pain	Falls Asleep
Irritating	Burning-Hot	Dreadful	Superficial Pain	Suffocating
Annoying	Drill Like	Fearful	Stinging	Punishing
Stiff or Tight	Heavy	Unhappy	Throbbing	Crawling
Exhausting	Numbness	Torturing	Sharp	Tender

**Have you ever been to a Chiropractor before for any condition?**

No,  Yes If Yes, Chiropractors Name: \_\_\_\_\_ Year: \_\_\_\_\_

Problem seen for: \_\_\_\_\_

**ARE YOU TAKING ANY MEDICATIONS?**

I am not taking any medications currently. Check any of the following that you are taking currently.

<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Anacin
<input type="checkbox"/> Anti-Inflammatory	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Bufferin
<input type="checkbox"/> Narcotics for Pain	<input type="checkbox"/> Advil / Motrin	<input type="checkbox"/> Stroke Prevention Meds.
<input type="checkbox"/> Heart Medications	<input type="checkbox"/> Birth Control Medications	<input type="checkbox"/> Other

**WHEN IS YOUR PAIN USUALLY BETTER?**

<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
<input type="checkbox"/> During Sleep Hours	<input type="checkbox"/> Lying Down Flat	<input type="checkbox"/> Standing
<input type="checkbox"/> Walking	<input type="checkbox"/> Sitting	<input type="checkbox"/> Rest
<input type="checkbox"/> Stress (mental) is Less	<input type="checkbox"/> Good Posture	<input type="checkbox"/> Exercise / Stretching

**HAS YOUR PAIN BEEN ASSOCIATED WITH:**

<input type="checkbox"/> Excessive fatigue-malaise	<input type="checkbox"/> Bowel or bladder disorders	<input type="checkbox"/> Night Pain or night time sweats
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Ovarian Pain	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Low Grade Fever	<input type="checkbox"/> Kidney Pain/Painful Urination	<input type="checkbox"/> Balance Problems

**DO YOU EXERCISE?**

<input type="checkbox"/> I do no regular exercise	<input type="checkbox"/> I exercise 1-2 times a week	<input type="checkbox"/> I exercise 3-5 times a week
<input type="checkbox"/> I stretch regularly	<input type="checkbox"/> I do weight lifting at gym/home	<input type="checkbox"/> I do cardiovascular work outs

I am willing to do exercise       I am not willing to do exercises       I do regular sports activities

### PAST AND PRESENT GENERAL HEALTH HISTORY PAGE 3

Check only those conditions that apply to you and indicate if you have had in the past or presently have:

YES	GENERAL QUESTIONS	PAST	PRESENT
<input type="checkbox"/>	I bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	I heal slowly	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	My body temperature is normally low ( feel cold) *	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Smoke cigarettes or use tobacco products	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Diabetic	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Dou you have a pacemaker, neck or chest shunt, any problems lying face down?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Dizziness, blacked out, or fainting spell history	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Epilepsy-Seizure-Convulsion History	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of gout, lupus, psoriasis, temporary paralysis, or spinal meningitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cancer history or treatment of any type	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Stroke history ( indicate and suspected strokes or transient ischemic attacks)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have scoliosis, spondylolisthesis, disc degeneration, or herniated disc	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have spina bifida, abdominal aneurysm, or vascular conditions	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Have you ever been hospitalized? Why?:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Coma from head injury or other problem	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have osteoporosis of your spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have osteoarthritis or rheumatoid arthritis of your spine or joints	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<b>Women Only: Check this box if you currently have any type of breast implants</b>	<b>N/A</b>	<b>N/A</b>
<input type="checkbox"/>	<b>Women Only: Check this box if there is any chance that you are currently pregnant</b>	<b>N/A</b>	<b>N/A</b>

### PRIOR INJURY OR MUSCULOSKELETAL PAIN HISTORY

(  I have no history of previous painful injury or pain ) If you have had prior injuries or pain, please check below:

<input type="checkbox"/> Work Injury	<input type="checkbox"/> Fall	<input type="checkbox"/> Sports Injury	<input type="checkbox"/> Lifting Injury	<input type="checkbox"/> Car Accident
<input type="checkbox"/> Motorcycle Injury	<input type="checkbox"/> Bicycle Injury	<input type="checkbox"/> Pedestrian Injury	<input type="checkbox"/> Military Injury	<input type="checkbox"/> Other Injury
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Neck Pain or Arm Pain	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Low Back / Leg Pain	<input type="checkbox"/> Other Pain

### FRACTURES / BROKEN BONES

(  I have never had any broken bones). If you have broken any bones, indicate where and when:

Region	Year	Region	Year
<input type="checkbox"/> Spinal Vertebra		<input type="checkbox"/> Skull	
<input type="checkbox"/> Collar Bone ( Clavicle )		<input type="checkbox"/> Rib Bone	
<input type="checkbox"/> Arm or Hand Pain		<input type="checkbox"/> Leg or Foot Bone	
<input type="checkbox"/> Pelvis Bone		<input type="checkbox"/> Other	

### PREVIOUS SURGERIES

(  I have never had any surgical procedure). If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
<input type="checkbox"/> Spine Surgery ( neck or back )		<input type="checkbox"/> Appendix	
<input type="checkbox"/> Disc Surgery ( neck or back )		<input type="checkbox"/> Gallbladder / Stomach / Kidney	
<input type="checkbox"/> Heart		<input type="checkbox"/> Cancer ( any type )	
<input type="checkbox"/> Tonsillectomy		<input type="checkbox"/> Rib / Collar Bone	
<input type="checkbox"/> Head / Brain		<input type="checkbox"/> Hernia	
<input type="checkbox"/> Shoulder / Arm Leg		<input type="checkbox"/> Other	