Welcome to Interstate Chiropractic

PATIENT INFORMATION

Name:_____ Date of Birth:_____ Male □ Female □

Address: _____ City: _____ State: _____ Zip: _____

Day Phone: _____ Evening Phone: _____ Cell Phone: _____

e-mail: _____ Soc Sec (if using insurance) _____

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Phone: _____

Referred to office: □ Web Site Search □ Social Med □ Friend/Family Member(name)_____

Payment for Service: □ Cash □ Check □ Credit Card □ Health Insurance □ Auto Insurance □ Work Injury Comp

Medical/Family History S= Self M=Mother F=Father
(Please indicate which conditions have been experienced by the above by checking the appropriate boxes)

S	M	F		S	M	F		S	M	F	
□	□	□	Sinus Trouble	□	□	□	Digestive Issues	□	□	□	Anxiety/Depression
□	□	□	Anemia	□	□	□	Cancer	□	□	□	Arthritis
□	□	□	Poor Circulation	□	□	□	Kidney Disorder	□	□	□	Polio
□	□	□	Asthma	□	□	□	Diabetes	□	□	□	HIV/Aids
□	□	□	Back/Neck Pain	□	□	□	Heart Condition	□	□	□	Hepatitis
□	□	□	Bone Fracture	□	□	□	High Blood Pressure	□	□	□	Rheumatic Fever
□	□	□	Concussion	□	□	□	Multiple Sclerosis	□	□	□	Scarlet Fever
□	□	□	Seizure	□	□	□	Parkinson's Disease	□	□	□	Tuberculosis
□	□	□	Headaches	□	□	□	Muscular Dystrophy	□	□	□	STD
□	□	□	Hepatitis	□	□	□	Numbness	□	□	□	Reproductive Disorder

Have you been treated by a physician for any health condition in the last year? □ Yes □ No

Describe Condition:_____ Date of last exam: _____

Describe Treatment:_____

Surgical History: □ None _____ Date: _____

_____ Date: _____

Accident History: □ Job □ Auto □ Other: _____ Date: _____

□ Job □ Auto □ Other: _____ Date: _____

□ Job □ Auto □ Other: _____ Date: _____

Primary Reason for your visit today: _____

Contributing Factors (if known) :_____

When and how did your symptoms begin? _____

_____

Is this condition: □ Gradual onset □ Job Accident □ Car Accident □ Illness □ Unknown

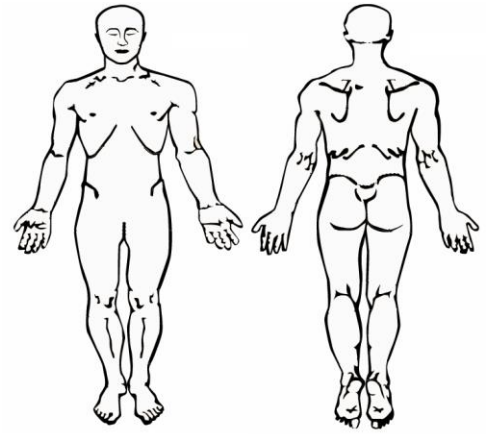
If you are experiencing pain is it described as: □ Dull □ Sharp □ Stabbing □ Achy

Do you have any tingling, numbness or loss of strength? □ No □ Yes : Describe: _____

_____

Since your symptoms started have they changed? □ The Same □ Improved □ Gotten worse
Please check the following that aggravates your condition:
□ Bending □ Reaching □ Coughing □ Sneezing □ Lifting □ Walking □ Turning your head □ Twisting
□ Standing □ Laying □Getting up from seated
Are your symptoms worse in: □ Morning □ Afternoon □ Night □ Same all the time

Please indicate where you are having the most issues/pain:



Please Check additional Symptoms you may be experiencing:

□ Blurred Vision	□ Shooting Pain	□ Loss of Concentration	□ Headache
□ Ringing in Ears	□ Muscle Jerking	□ Memory Loss	□ Light Bothers Eyes
□ Numb Fingers	□ Muscle Weakness	□ Depression	□ Fever
□ Numb Toes	□ Upset Stomach	□ Insomnia	□ Fainting
□ Cold Feet	□ Sleep Apnea	□ Loss of Balance	□ Diarrhea
□ Tingling in Hands	□ Cold Sweats	□ Shortness of Breath	□ Loss of Bladder Control

Have you had this problem before? □ Yes □ No When? _____

How was it treated?_____
Have you been seen by a chiropractor before?□ Yes □ No For the same problem? □ Yes □ No
Any allergies to medications or supplements?: □ Yes □ No
Please list any medications or supplements: _____

_____

Are you pregnant? □ Yes □ No How far along are you in your pregnancy?: _____

Hobbies/Activities: _____

_____

The information I have provided is accurate to the best of my recollection and is intended to provide Interstate Chiropractic with necessary information in order to diagnose my condition(s) and to determine the appropriate treatment. By providing this information it is my intent to be examined, diagnosed, and treated by Interstate Chiropractic. I acknowledge that treatment does not guarantee intended results. I authorize faculty of Interstate Chiropractic to perform or participate in the proposed treatment. I further authorize the treating doctor and his/her assistants to perform procedures that are necessary in the exercise of his/her professional judgment during the course of treatment:

Patient's Signature _____ Date: _____

Consent to Treatment of a Minor(if applicable)

I hereby authorize designated staff of Interstate Chiropractic to administer treatment as they deem necessary to the following:

Minors Name: _____

Signature of Guardian: _____ Date: _____