German Village Chiropractors

Confidential Patient Health Information

Personal Information:

☐ Mr. ☐ Mrs. ☐ Miss Name: _____ Age: _____ ☐ M ☐ F

Address: _____ City/State: _____ ZIP: _____

SS# _____/_____/_____ Birthdate: _____/_____/_____ Drivers License #: _____ Marital Status: ____

Home Phone: ( ) ____ - _____ Work Phone: ( ) ____ - _____ X____ Other Phone: ( ) ____ - _____

Employer: _____ Occupation: _____ How Long? _____

Nearest Relative: _____ Relationship: _____ Phone: ( ) _____ - _____

E-mail Address (for Patient Newsletter): _____

HOW WERE YOU REFERRED? _____

Reason for your Visit:

Have you been to this clinic before? ☐ Yes ☐ No

Purpose of this appointment: _____

Reason for your visit is a result of (please circle): work injury, auto accident, trauma, chronic problem, other

Please describe the pain and its location: _____

Date of accident/injury, or when condition began: _____/_____/_____

Is condition getting worse? ☐ Yes ☐ No ☐ stays the same ☐ Comes and goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other

Have you been treated by another doctor for this condition? ☐ Yes ☐ No

If yes, please name doctor/health care facility: _____

Insurance Information:

Company Name: _____ Phone: ( ) _____ - _____

Address: _____ City/ State: _____ ZIP: _____

Name of Insured: _____ SS# _____/_____/_____

Insured ID (if different than SS#): _____ Insured's Birthdate: _____/____/_____

Policy/Group #: _____ Plan Name: _____

Relationship to you: _____ Insured's Employer: _____ Effective Date: ___/____/____

Name of Secondary Insurance Company (if any) _____

Phone Number of Insurance Company _____

Name of Insured _____

If Worker's Compensation or Personal Injury, have you been advised by an attorney? Yes ☐ No ☐

If yes, attorney's name, address, and telephone number _____

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Your Health History (circle "C" if the problem is a current one and "P" if you've had the problem in the past)

General
C P Allergy
C P Convulsions
C P Dizziness
C P Fainting
C P Headache
C P Sudden Weight Loss
C P Fatigue

Muscle & Joint
C P Arthritis
C P Bursitis
C P Low Back Pain
C P Neck Pain/Stiffness
C P Shoulder Pain
C P Spinal Curvature
C P Midback Pain

Eyes, Ears Nose & Throat
C P Deafness
C P Ear-ache
C P Failing Vision
C P Nosebleeds
C P Sinus Infections
C P Strep Throat
C P Thyroid Problems

Gastrointestinal
C P Colon Probs.
C P Constipation
C P Diarrhea
C P Gall Bladder
C P Hemorrhoids
C P Hernia
C P Liver Probs
C P Nausea/Vomiting

Respiratory
C P Asthma
C P Chest Pain
C P Chronic Cough
C P Spitting up Blood

Pain or Numbness in:
C P Shoulders/Arms
C P Elbows/Hands
C P Hips/Legs
C P Ankles/Knees/Feet

Skin Problems
C P Bruise Easily
C P Hives or Allergic Reaction
C P Skin Rash
C P Acne

Other
C P Alcoholism
C P Anemia
C P Cancer
C P Diabetes
C P Measles
C P Stroke
C P Rheum.Fever
C HIV/AIDS

Cardio-Vascular
C P Hard. Of Arteries
C P High Blood Pressure
C P Low Bld. Pressure
C P Rapid/Slow Heartbt.
C P Swelling of Ankles
C P Arrythmia

Genito-Urinary
C P Bedwetting
C P Frequent Urination
C P Kidney Infection
C P Painful Urination
C P Prostate Trouble
C P Kidney Stones

For Women Only
C P Cramps or Backache w/cycle
C P Excessive Menstral Flow
C P Irregular Cycle
C P Lumps in Breast
C P Pain w/intercourse
C P Pelvic Inflammatory Disease

Please list any medications you are taking, (including OTC)_____

Please list any medications that you are allergic to: _____

Please list all surgeries and dates_____

_____

Medical Physician's name_____

Your Family History (some health problems are the result of familial tendencies)

Family Member	Illnesses	Age (or) Age Died	Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			

Social History

Do you smoke? ☐ Yes ☐ No If yes, how may packs per day? _____ For how long?_____
Do you consume alcoholic beverages? ☐ Yes ☐ No If yes, socially? Moderately? Daily? Rarely?
Do you exercise regularly? ☐ Yes ☐ No If yes, daily? 3x/week 1x/week Other (specify): _____

In the event of an emergency...

Who should we contact? _____ Relationship: _____

Home Phone #: ( ) _____-_____ Work Phone #: ( ) _____-_____ X _____