Gillis Chiropractic Clinic
PERSONAL HISTORY

Date:________________

Name:______________________________ Social Security #:__________________________

Address:________________________________City:____________State:________Zip Code:__________

Home Phone:__________________Cell Phone:_________________Business Phone:_________________

Birthdate:____________________Age:________Sex:_________Height/Weight:_____________________

Name of your Employer:_______________________________Type of Work:_________________________

Type of Insurance:_____________________Martial Status:_________Name of Spouse:_______________

Spouse's Employer:______________________Spouse's Social Security #:_________________________

Type of Insurance:______________________Are you covered by this insurance?:__________________

Name and Phone Number of Nearest Relative (Outside of your Home):______________________________

Who is responsible for your bill? (circle): Insurance Workman's Compensation Medicaid Medicare Self Auto Insurance Other:______________________

Referred by (circle): TV Yellow Pages Previous Patient Internet Facebook

Friend:_________________ Other:__________

PAST HEALTH HISTORY

SURGERIES: (Spinal or joint) ____

____

ACCIDENTS OR FALLS: (Please Describe) ____

____

FRACTURES OR DISLOCATIONS:____

____

HABITS: Sleep (hours):__________ Coffee:__________ Alcohol:__________ Exercise:__________ Tea:__________ Tobacco:__________

Are you taking any medications? (Please explain for what):________________________________

____

Are you Pregnant (circle): Yes No If yes, how far along:________________ Pacemaker (circle): Yes No

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Gillis Chiropractic to release any information including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such chiropractic care to third payers and/or health practitioners. I authorize and request my insurance company to pay directly to Gillis Chiropractic or chiropractic group insurance benefits otherwise payable to me. A fee schedule is available upon request. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

______________________________________ ____________________

Patient Signature Date

Name________________________ Date of Birth____________________ Date______________

WHEN DID SYMPTOMS APPEAR?____

WAS THIS WORK OR AUTO RELATED?____

HOW DID SYMPTOMS OCCUR?____

____

____

SYMPTOMS

Please Circle All the Following Symptoms you have NOW.

	Side Pain 1-10		Side Pain 1-10	
Headaches	R / L	Pins/Needles in legs, feet, toes	R / L	Sinus Trouble
Neck Pain	R / L	Numbness in legs, feet, toes	R / L	Difficult Breathing
Stiff Neck	R / L	Pain in legs, feet, toes	R / L	Asthma
Fainting/Dizziness	R / L	Chest pain	R / L	Previous heart attack
Pins/Needles in arms, hands, fingers	R / L	High Blood Pressure/ Low Blood Pressure	R / L	Joint Swelling
Numbness in arms, hands, fingers	R / L	Pain between shoulder blades	R / L	Stomach Pain
Pain in arms, hands, fingers	R / L	Shoulder Pain	R / L	Bowel Changes
Mid Back Pain	R / L	Elbow Pain	R / L	Bladder Changes
Low Back Pain	R / L	Foot/Ankle Pain	R / L	Epilepsy
Hip Pain	R / L	Spinal Curve/ Scoliosis	R / L	Cancer

Other____

Type of Pain (Circle): Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Other

What aggravates your symptoms?_____________________________________

What gives you relief of your symptoms?_______________________________

Are you presently being treated for any other condition? Yes No If yes, what?______________ ______________________ By who?__________________________

Have you ever had prior Chiropractic Care? Yes No If yes, who?______________________

(For Doctor's Use Only)
ONSET:_____________________________ ETIOLOGY:___________________________

HX OF BP:___________________________ PRIOR TX:___________________________