the CONNECTION
a chiropractic place

Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST.

PATIENT INFORMATION Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____

PHONE NUMBERS (Home): _____ (Work): _____ Other: _____

☐ MALE ☐ FEMALE MARTIAL STATUS: _____

OCCUPATION: _____ EMPLOYER: _____

Referred to this office by: ☐ Friend/Family Member Name? _____

☐ Event or advertisement _____

Payment for services will be paid by: ☐ Cash ☐ Check ☐ Credit Card
☐ Medicare ☐ Automobile Insurance ☐ Worker's Compensation

MEDICAL/FAMILY HISTORY

S=Self M=Mother F=Father (Please indicate which conditions have been experienced by person by marking appropriate boxes.

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	Diabetes	☐	☐	☐	Muscular Dystrophy
☐	☐	☐	Anemia	☐	☐	☐	Dislocated Joints	☐	☐	☐	Neck Pain
☐	☐	☐	Arthritis	☐	☐	☐	Epilepsy	☐	☐	☐	Nervousness
☐	☐	☐	Asthma	☐	☐	☐	German Measles	☐	☐	☐	Numbness
☐	☐	☐	Back Pain	☐	☐	☐	Headaches	☐	☐	☐	Polio
☐	☐	☐	Bladder Trouble	☐	☐	☐	Heart Trouble	☐	☐	☐	Poor Circulation
☐	☐	☐	Bone Fracture	☐	☐	☐	Hepatitis	☐	☐	☐	Reproductive Disorders
☐	☐	☐	Bowel Control Loss	☐	☐	☐	High Blood Pressure	☐	☐	☐	Rheumatic Fever
☐	☐	☐	Cancer	☐	☐	☐	HIV/ARC	☐	☐	☐	Serious Injury
☐	☐	☐	Chest Pain	☐	☐	☐	Indigestion	☐	☐	☐	Sinus Trouble
☐	☐	☐	Concussion	☐	☐	☐	Kidney Disorder	☐	☐	☐	Tuberculosis
☐	☐	☐	Convulsions	☐	☐	☐	Menstrual Cramps	☐	☐	☐	Venereal Disease
				☐	☐	☐	Multiple Sclerosis				

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

Condition Treated: _____ Date of Last Physical: _____

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SURGICAL HISTORY:

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____

Have you ever had a metal implant? ☐ Yes ☐ No Ever had a gunshot wound? ☐ Yes ☐ No

ACCIDENT HISTORY

☐ Job ☐ Auto ☐ Other _____ Date:_____
☐ Job ☐ Auto ☐ Other _____ Date:_____
☐ Job ☐ Auto ☐ Other _____ Date:_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS: Please Rate Your Symptoms 1-10, 1 being least worrisome

_____ _____

_____ _____

_____ _____

_____ _____

SYMPTOMS ARE WORSE IN ☐ Morning ☐ Afternoon ☐ Night

WHEN AND HOW OCCURRED? _____

_____

SYMPTOMS DEVELOPED FROM: ☐ JOB RELATED INJURY ☐ AUTO ACCIDENT ☐ OTHER ACCIDENT
☐ ILLNESS ☐ UNKNOWN CAUSE ☐ GRADUAL ONSET DATE OCCURRED: _____

SYMPTOMS HAVE PERSISTED FOR # ____ HOUR(S) ____ DAY(S) ____ WEEK(S) ___ MONTH(S) ____ YEAR(S)

SYMPTOMS/COMPLAINTS: ☐ COME & GO ☐ ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: ☐ NO ☐ YES WHEN? _____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS? _____

_____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S): _____

_____

ARE YOU ALLERGIC TO MEDICATIONS? ☐ NO ☐ YES Which one(s):_____

ARE YOU TAKING ANY MEDICATIONS? ☐ NO ☐ YES What:_____

ARE YOU PREGNANT? ☐ NO ☐ YES ARE YOU BREASTFEEDING? ☐ NO ☐ YES

Patient signature:_____ Date:_____

Parent/Guardian signature:_____ Date:_____