LONGIE CHIROPRACTIC

910 Thompson Blvd.
Sedalia, MO 65301
660-829-2600

ABOUT THE PATIENT

Name: _____ Birthdate: _____ Age: _____

Address: _____ City _____ State: _____ Zip: _____

Phone: _____ Alt. Phone: _____ Work Phone: _____ Gender: ☐ M ☐ F

Employer: _____ Occupation: _____

Email: _____ Have you been to a chiropractor before? ☐ Yes ☐ No

Significant Other's Name: _____ Kid's Names and Ages: _____

Emergency Contact: _____ Phone Number: _____

Name of Medical Doctor(s): _____

REASON FOR SEEKING CARE

Complaint 1: _____ How long? _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same

☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the A.M. ☐ Worse in the P.M ☐ Pain radiates to: _____

Complaint 2: _____ How long? _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same

☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the A.M. ☐ Worse in the P.M ☐ Pain radiates to: _____

Complaint 3: _____ How long? _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same

☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the A.M. ☐ Worse in the P.M ☐ Pain radiates to: _____

Complaint 4: _____ How long? _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same

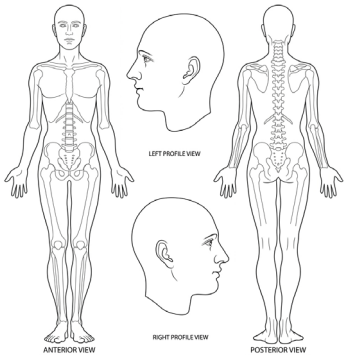
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the A.M. ☐ Worse in the P.M ☐ Pain radiates to: _____

1. What is affected: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving
   ☐ Other: _____
2. What makes it better? _____
3. What makes it worse? _____
4. What doctors have you seen for this? _____
5. Types of treatment: _____
6. Results: _____

Notes: _____

Are you pregnant?
☐ Yes ☐ No

Please mark all areas of concern



AUTHORIZATION

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Longie Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- Person responsible for this account if other than the patient: _____
- For my balance my preferred payment method is: ☐ Cash ☐ Check ☐ Credit Card

Signing means you approve a long-term authorization for all occasion of service.

_____ _____

Patient / Parent Signature Date