SOWERS CHIROPRACTIC CENTER

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT Date_____

Name_____ Social Security_____ Home Phone_____

Address_____ City_____ Zip Code_____

Age_____ Birth Date_____ Marital: M S D W How Many children?_____ Email_____

Occupation_____ Employer_____

Address_____ Office Phone_____

Insured's name if patient is a dependant_____ Social Security_____

Name of Insurance Company_____ Address_____

Name of Spouse_____ Birth Date_____ Occupation_____

Employer_____ Address_____

Patient's nearest relative or friend (not living at the same address)_____ Phone_____

Address_____

Referred by_____

Is condition due to injury or sickness arising out of patient's employment?_____

Date symptoms appeared or accident happened:_____ Have you lostany days from work?_____

Patient ever had same or similar condition? ☐ Yes ☐ No If yes, when and describe_____

_____

Date of last physical examination:_____ Female: Are you pregnant?_____

What operations have you had?_____

Serious illnesses?_____ Fractured bones? _____

Have you ever been under Chiropractic Care? ☐ Yes ☐ No Doctor's name_____

Payment: ☐ Cash ☐ Check ☐ Visa/Mastercard

Have you ever suffered from:

- ☐ allergy
- ☐ dizziness
- ☐ fatigue
- ☐ headaches
- ☐ loss of sleep
- ☐ ulcers
- ☐ numbness
- ☐ arthritis
- ☐ bursitis
- ☐ foot trouble
- ☐ low back pain
- ☐ neck pain or stiffness
- ☐ Tuberculosis
- ☐ sciatica
- ☐ scoliosis
- ☐ swollen joints
- ☐ colon trouble
- ☐ diarrhea
- ☐ difficult digestion
- ☐ nausea
- ☐ asthma
- ☐ deafness
- ☐ ear noises
- ☐ enlarged thyroid
- ☐ eye pain
- ☐ failing vision
- ☐ venereal disease
- ☐ hay fever
- ☐ sinus infections
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ pain over heart
- ☐ poor circulation
- ☐ rapid heartbeat
- ☐ slow heartbeat
- ☐ anemia
- ☐ stroke
- ☐ chest pain
- ☐ difficult breathing
- ☐ pleurisy
- ☐ swelling of ankles
- ☐ cancer
- ☐ varicose veins
- ☐ bed-wetting
- ☐ frequent urination
- ☐ kidney infection or stone
- ☐ prostate trouble
- ☐ cramps
- ☐ excessive menstrual flow
- ☐ irregular cycle
- ☐ diabetes
- ☐ polio

Tingling or numbness in:

- ☐ shoulders ☐ hips
- ☐ arms ☐ legs
- ☐ elbows ☐ knees
- ☐ hands ☐ feet

Are you wearing:

heel lifts ☐ yes ☐ no

arch supports ☐ yes ☐ no

PLEASE PRINT

Purpose of this appointment (Major complaint)_____

_____

What activities aggravate your condition?_____

Is this condition getting progressively worse? ☐ yes ☐ no ☐ constant ☐ comes and goes

Is this condition interfering with your ☐ work ☐ sleep ☐ daily routine ☐ other

_____

How long has this been going on?_____

Other Doctors seen for this condition._____

Have you been treated for any health conditions by a physician in the last year? ☐ yes ☐ no

If yes, describe_____

What medications are you taking?_____

Family doctor's name_____address_____
Send a report? ( ) yes ( ) no

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature_____Date_____

Guardian or spouse's signature authorizing care_____Date_____

Information taken by_____Date_____

Notes:_____

_____

_____

_____

_____

_____

_____

_____

_____