CONFIDENTIAL CONFIDENTIAL

PATIENT INFORMATION SHEET

Please Print Clearly and Fill Out Completely

How Did You Hear About our Office? (Please Mark all that Apply)

- ☐ Referral: _____
- ☐ Website
- ☐ Insurance List
- ☐ Yellow Page Ad
- ☐ Mail
- ☐ Sign
- ☐ Location
- ☐ Newspaper
- ☐ Other: _____

Patient Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____

Cell Phone: _____

Social Security Number: _____

Driver License Number: _____

Date of Birth: _____ Age: _____

Sex: M F Marital Status: M S W D

Height: _____ Weight: _____

Number of Children: _____

Occupation: _____

Employer: _____

Address: _____

City/State/Zip: _____

Work Phone: _____

Name of Spouse: _____

Occupation: _____

Employer: _____

Emergency Contact: _____

Address: _____

Phone: _____

Purpose for today's visit: _____

_____

Previous Chiropractor: _____

Remarks/Additional Information: _____

_____

Primary Insurance: _____

Secondary Insurance: _____

Guarantor (if minor): _____

Address: _____

City/State/Zip: _____

Phone Number: _____

Social Security Number: _____

Driver License Number: _____

Relationship to Patient: _____

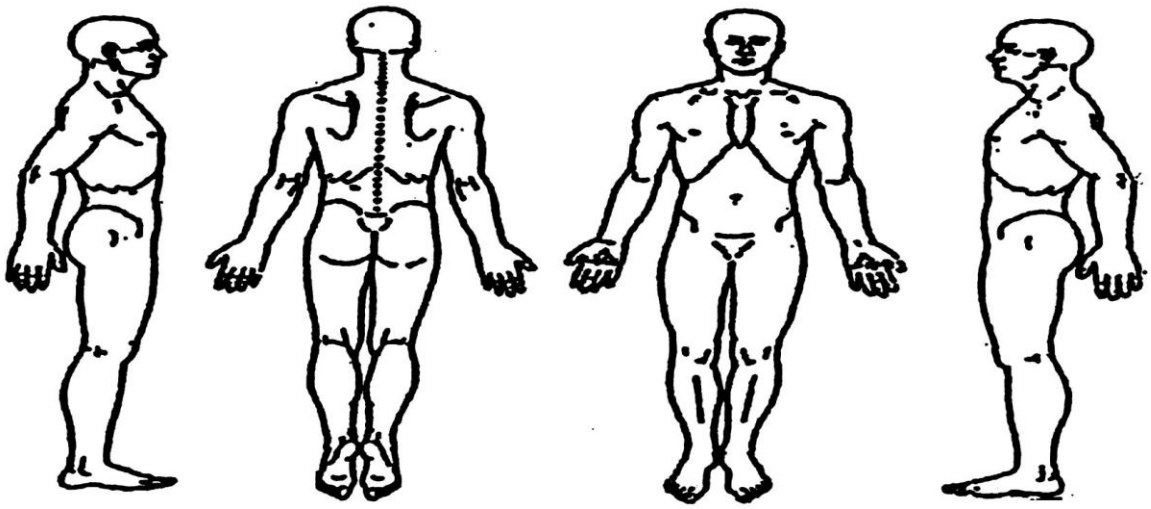
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Funk Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Funk Chiropractic 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. All accounts past 60 days will be charged interest at a rate of 18% per year. I understand that a handling fee will be added to any returned checks and that in the event Funk Chiropractic should find it necessary to refer my account to a collection service, I will be charged a delinquent fee of 10% of the total bill or $25.00, whichever is greater. 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/Guarantor: _____ Date: _____

(*Rev. 084/18*)

Indicate on the drawings below where you have pain/symptoms:

XX	**Pain**
NN	**Numbness**
++	**Tingling**
→→	**Radiating Pain**
O	**Muscle Ache**



For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Medical Marijuana
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Allergies
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Chronic Sinusitis
□	□ Hand Pain	□	□ Painful Urination	□	□ Asthma
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Depression
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ Systemic Lupus
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss	□	□ Epilepsy
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	□	□ Dermatitis/Eczema/Rash
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ HIV/AIDS
□	□ Joint Pain/Stiffness	□	□ Ulcer		
□	□ Arthritis	□	□ Hepatitis		
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder	**For Females Only**	
□	□ Cancer	□	□ General Fatigue	□	□ Birth Control Pills
□	□ Tumor	□	□ Muscular In-coordination	□	□ Hormonal Replacement
□	□ Dizziness	□	□ Visual Disturbances	□	□ Pregnancy
□	□ Other: _____				

Using a scale from 0-10 (10 being the worst), how would you rate your problem?
(Please List Each Problem)

_____	0	1	2	3	4	5	6	7	8	9	10	(*Please circle*)
_____	0	1	2	3	4	5	6	7	8	9	10	
_____	0	1	2	3	4	5	6	7	8	9	10	
_____	0	1	2	3	4	5	6	7	8	9	10	

How long have you had this problem? _____ □ Days □ Weeks □ Months □ Years

How do you think your problem began? _____

How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

How would you describe the type of pain? (Mark all that apply)

□ Sharp □ Numb □ Sharp with motion
□ Dull □ Tingly □ Shooting with motion
□ Diffuse □ Stiff □ Stabbing with motion
□ Achy □ Shooting □ Electric like with motion
□ Burning □ Other: _____

Does the pain travel to any other part of your body: □ Yes □ No
If yes, Where _____

How are your symptoms changing with time?
□ Getting Worse □ Staying the Same □ Getting Better

How would you rate your overall health? □ Excellent □ Good □ Fair □ Poor

What concerns you the most about your problem; what does it prevent you from doing?

_____

Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Primary Care Physician □ **No Other Providers**
□ ER physician □ Orthopedist □ Other: _____
□ Massage Therapist □ Physical Therapist
How Long Ago: _____ □ Days □ Weeks □ Months □ Years

Have you had any Radiological test for this condition: □ X-Rays □ MRI □ CT □ **NONE**
Date Study Performed: _____

List all prescription/Over-the-counter medications you are currently taking: □ **NONE**

_____
_____

List all Vitamins or Supplements that you are currently taking: □ **NONE**

_____

List all surgical procedures you have had: (Include Month & Year) □ **NONE**

_____
_____

Significant Past Trauma: (Include Month & Year) □ **NONE**

_____
_____

Past Hospitalizations: (Include Month & Year) □ **NONE**

_____
_____