Welcome to Woodbury Chiropractic Center

Patient Information

Thank you for choosing Woodbury Chiropractic Center for your health care needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

(please print clearly) Date: ____________________

Name: (Mr. Mrs. Ms Dr.) ____ SS/HIC/Patient ID #: ________________
First Middle Initial Last

Address: ________________________ City: ________________ State: _____ Zip Code: __________

Mailing address if different: ____

Sex: ❑ Female ❑ Male Birthdate: ________________ E-mail: ____________________________

Home Phone: (_____)______________ Cell Phone: (_____)______________ Work Phone: (_____)______________

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered # of Children _____

Patient Employer/School: ______________________________ Occupation: ______________________

Employer/School Address: ____________________ City: ________________ State: _____ Zip Code: __________

Spouse or parent's name: ____________________ Employer: ______________ Work Phone: (_____)______________

Whom may we thank for referring you to us? ____

Person to contact in case of emergency: ______________________________ Phone: (_____)______________

My goal for consulting with the doctor:

❑ Temporary Relief ❑ Lasting Correction ❑ I'll let the doctor recommend the best type of care for me

Symptoms

Reason for visit: ____

____

How serious do you think your problem is? ❑ Annoying ❑ Mild Limitations ❑ Severe Limitations ❑ Can't Function

Other complaints: ____

When did you first notice the symptoms? ____________________ Have you had similar conditions in the past? Y N

Is the condition getting progressively worse? ________ Where specifically is the problem(s) located? ______________

Which activities are difficult to perform? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑ Other

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

Rate the severity of your pain. (1 = mild pain or discomfort, to 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

❑ Constant ❑ Comes and goes: ❑ 0-25% ❑ 26-50% ❑ 51-75% ❑ 76-100% of the time

How has this problem affected your life?

1) Difficulty in performing basic activities: ❑ Bathing ❑ Showering ❑ Shaving ❑ Dressing ❑ Sleeping ❑ Eating

2) Daily duties, difficulty in performing: ❑ Cleaning ❑ Washing Dishes ❑ Sweeping/Mopping

3) Hobbies, slowing or prevention of certain hobbies/recreation: ______________________________

4) Work: ❑ I Just Get Through = Slower Production Due to Pain ❑ Cannot work at all since ______________

5) Family/Social: ❑ Not as Easy Going ❑ Grumpy Feeling Due to Pain ❑ Depression/Angry due to pain

What activity would you like to be able to do again that is difficult or you cannot do now? ______________

...continued on next page

Is this a new or an aggravation of an old problem? ______________________________

Trauma from birth to present, please list by date and describe:

1) Injuries and falls: ______________________________

2) Broken bones: ______________________________

3) Car/Bike accidents: ______________________________

Do you have any metal in your body? ❏ Yes ❏ No If yes, where? ______________________________

Have you had any previous Chiropractic Care? __________ Dr. Name/address/phone: ______________________________

____

What treatment have you received for your condition?

❏ Now on medication ❏ Surgery ❏ Physical Therapy ❏ Other ______________________________

Recent MRI's, X-Rays, CT Scans or any other Diagnostic Testing? Date/where taken: ______________________________

Name and address of other doctor(s) who have treated you for your condition: ______________________________

____

Family Dr/PCP name address phone number: ______________________________

Date of last physical: ______________________________

Health History *Check only those conditions which are applicable:*

❏ AIDS/HIV	❏ Cataracts	❏ Hepatitis	❏ Mumps	❏ Stroke
❏ Alcoholism	❏ Chemical Dependency	❏ Hernia	❏ Osteoporosis	❏ Suicide Attempts
❏ Allergy Shots	❏ Chicken Pox	❏ Herniated Disc	❏ Pacemaker	❏ Thyroid Problems
❏ Anemia	❏ Depression	❏ Herpes	❏ Parkinson's Disease	❏ Tonsillitis
❏ Anorexia	❏ Diabetes	❏ High Blood Pressure	❏ Pinched Nerve	❏ Tuberculosis
❏ Appendicitis	❏ Emphysema	❏ High Cholesterol	❏ Pneumonia	❏ Tumors, Growths
❏ Arthritis	❏ Epilepsy	❏ Kidney Disease	❏ Polio	❏ Typhoid Fever
❏ Asthma	❏ Fractures	❏ Liver Disease	❏ Prostate Problems	❏ Ulcers
❏ Bleeding Disorders	❏ Glaucoma	❏ Measles	❏ Prosthesis	❏ Vaginal Infections
❏ Breast Lump	❏ Goiter	❏ Migraine Headaches	❏ Psychiatric Care	❏ Venereal Disease
❏ Bronchitis	❏ Gonorrhea	❏ Miscarriage	❏ Rheumatoid Arthritis	❏ Whooping Cough
❏ Bulimia	❏ Gout	❏ Mononucleosis	❏ Rheumatic Fever	❏ Other __________
❏ Cancer	❏ Heart Disease	❏ Multiple Sclerosis	❏ Scarlet Fever	__________

Dates of last exams: ______________________________

(Woman) Are you pregnant? ❏Yes ❏No Nursing? ❏Yes ❏No Taking Birth Control Pills? ❏Yes ❏No

List any types of surgeries which you have had and the dates which they occurred: ______________________________

____

Previous accidents/ Auto/Workers Comp/Personal: ______________________________

Date/type of injury: ______________________________

Please list all medications you are currently taking: ______________________________

Allergies/Age of mattress: ______________________________

Daily Habits

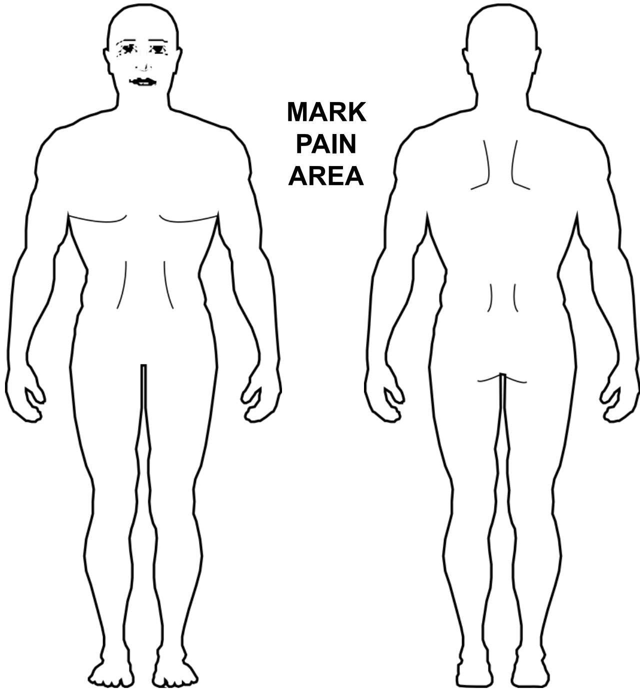
What type of exercise do you perform on a daily basis? ❏ None ❏ Moderate ❏ Heavy

What do your daily work habits include? ______________________________

What vitamins do you currently take? ______________ Nutritional supplements (if any)? ______________________________

Do you smoke? ❏ Yes ❏ No How much per day? ______________________________

How much liquor do you consume weekly? _______ How many caffeinated beverages do you consume daily? __________



+++ Burning   000 Stabbing
--- Sharp   III Consistent

Additional details can be provided below

____
____
____
____
____
____
____

Insurance Information

Name of insured: ______________________ Relationship to patient: ______________________

Birthdate: ______________ Social Security#:: ______________ Date employed: ______________

Name of employer: ________________________________ Work Phone: (_____)______________

Address: ______________________ City: ______________ State: _____ Zip Code: __________

Insurance Co.:____ Phone: (_____)______________

Group #: ____________________________ Employer #: ____________________________

Insurance Co. address: ________________ City: ______________ State: _____ Zip Code: __________

How much is your deductible/copay?_________ How much have you used? _________ Max. annual benefit?____________

Do you have additional insurance? ❑ Yes ❑ No **If Yes, please complete the following:**

Name of insured: ______________________ Relationship to patient: ______________________

Birthdate: ______________ Social Security#:: ______________ Date employed: ______________

Name of employer: ________________________________ Work Phone: (_____)______________

Address: ______________________ City: ______________ State: _____ Zip Code: __________

Insurance Co.:____ Phone: (_____)______________

Group #: ____________________________ Employer #: ____________________________

Insurance Co. address: ________________ City: ______________ State: _____ Zip Code: __________

Responsible Party

Name of person responsible for this account: ____________________________________

Relationship to patient:__________________________________ Phone: (_____)______________

Address: ______________________ City: ______________ State: _____ Zip Code: __________

Name of employer: ________________________________ Work Phone: (_____)______________

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________ and assign directly to Woodbury Chiropractic Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Woodbury Chiropractic Center may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I understand and agree that health and accident 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 collection from the Insurance Company. However, I clearly understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

____ ______________

Signature of Patient, Parent, Guardian or Personal Representative — Date

____ ______________

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Family Health Information

Name	Relation	Past/Present Health Problems