Main Street Chiropractic

Patient Information & History

Date:_____

1 PATIENT INFORMATION

Name: _____

(First) (Initial) (Last) (Name called by)

Address: _____

_____

Birthday: _____ Age: ____ ☐ Male ☐ Female

Social Security # _____/_____/_____

Occupation: _____

Employer: _____

Parents Name(if a minor):_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Seperated

Spouse's Name: _____

# of Children: __Name(s)_____

2 INSURANCE

Who is responsible for this account?_____

Relationship to patient_____

Insurance company_____

Insurance ID number_____

Group / Claim number_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Insurance company_____

Subscriber # and name_____

Birthdate_____Group #_____

Please present insurance card(s) so we can put a copy in your file.

3 ACCIDENT INFORMATION

Is your condition due to an accident? ☐ No ☐ Yes Date: _____

Type of accident? ☐ Automobile ☐ Work ☐ Home ☐ Other

To whom have you reported the accident?

Insurance ☐ Worker's Comp ☐ Employer ☐ Other_____

Attorney Name (If applicable)_____

4 CONTACT INFORMATION

Home phone_____

Cell phone_____

Work Phone_____Ext_____

Email_____

Best way to reach you ☐ Home ☐ Cell ☐ Work ☐ Email

IN CASE OF EMERGENCY, CONTACT

Name_____Relationship_____

Home Phone_____Cell_____

5 PATIENT CONDITION

What is your major symptom/problem? _____

When did your symptoms begin? _____

Have you had this problem before? _____

Is your condition getting progressively worse? Yes ☐ No ☐

Is this problem: ☐ constant ☐ comes and goes

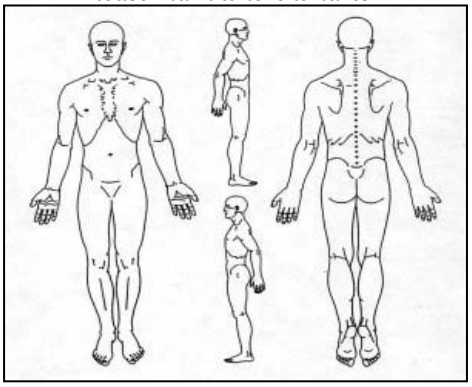
How does it Feel? ☐ Burning ☐ Sharp ☐ Shooting ☐ Dull ☐ Aching ☐ Stiff

☐ Tingling ☐ Throbbing ☐ Swelling ☐ Other_____

Circle below the severity of your pain on a scale of 0 to 10:

(No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe pain)

Please mark where it hurts



What makes your condition better? _____

What makes your condition worse? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities/movements that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Driving ☐ Reading ☐ Getting Up

- Please continue on the back -

6 HEALTH HISTORY

What other treatments have you had for this condition?

☐ Chiropractic ☐ Orthopedic ☐ Neurologist ☐ Physical Therapy ☐ Medication ☐ Surgery

Name of other doctors who have treated you for this condition_____

Describe the other doctor's treatment for your condition_____

Previous Chiropractic care? ☐ No ☐ Yes Date_____ ☐ Local ☐ Out of state _____

Date of Last: Physical Exam_____ Spinal x-ray_____ MRI _____

Spinal Exam _____ Dental x-ray_____ CT- Scan _____

List any Medications you are taking_____

Vitamins / Herbs / Minerals _____

Females: Are you Pregnant ☐ Yes ☐ No Beginning of last menstrual cycle_____

Check any of the following conditions you have had:

☐ AIDS/HIV
☐ Allergies
☐ Anxiety/Depression
☐ Arm/shoulder pain
☐ Arthritis
☐ Asthma
☐ Bladder problems
☐ Cancer
☐ Chronic fatigue
☐ Deafness
☐ Diabetes
☐ Digestion problems
☐ Earache
☐ Ear ringing
☐ Epilepsy
☐ Headaches
☐ Headaches - Migraine
☐ Heart Disease
☐ Hemorrhoids
☐ Herniated disk
☐ High blood pressure
☐ Insomnia
☐ Irregular cycle
☐ Kidney problems
☐ Leg pain
☐ Low back pain
☐ Neck pain
☐ Osteoporosis
☐ Poor circulation
☐ Prostate problems
☐ Rheumatoid Arthritis
☐ Sciatica
☐ Shingles
☐ Sinus infection
☐ Stroke
☐ Thyroid problems
☐ TMJ
☐ Venereal disease
☐ Vertigo/Dizziness

STRESSORS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/ Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

Have you had any:	**Description**	**Date**
Automobile accidents	_____	_____
Surgeries	_____	_____
Broken bones	_____	_____
Falls/Head injuries	_____	_____

7 AUTHORIZATION

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Main Street Chiropractic / Woody Brown D.C., P.A. to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Signature Date Parent (if patient is a minor)