PREMIER CHIROPRACTIC CLINIC

PLEASE ONLY FILL THOSE THAT APPLY TO YOU

Date: ___/___/___

Patient Information

Patient Title: *(check one)* ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Prof. ☐ Rev.

First Name _____ Middle Name _____ Nick Name _____

Last Name _____ Suffix _____ Previous Name _____

Address 1 _____

City _____ State _____ Zip Code _____

Primary Phone _____ Mobile Phone _____

Email _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Referred by: ☐ Patient/Friend ☐ Physician ☐ Advertisement ☐ Community Event ☐ Sports Event

Community Event Name of person or event: _____

Contact Method *(check one)* ☐ Primary Phone ☐ Secondary Phone ☐ Mobile Phone ☐ Email

Date of Birth ____/____/____ Age _____ Gender *(check one)* ☐ Male ☐ Female ☐ Unspecified

Marital Status *(check one)* ☐ Single ☐ Married ☐ Other Spouse's Name: _____

Employment Status *(check one)*

☐ Employed ☐ FT Student ☐ PT Student ☐ Other ☐ Retired ☐ Self Employed

Do you prefer Appointment Reminders? ☐ YES ☐ NO

If yes, what method of contact do you prefer? ☐ Phone ☐ Text ☐ Email

Have you previously been a patient in our Clinic? ☐ YES ☐ NO; If Yes: Date _____

Name of your Health Insurance Company: _____

Insurance Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

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Date: ___/___/___

Patient Condition

Reason(s) for visit: _____

Is this condition due to an accident? ☐ Yes ☐ No ☐ Auto ☐ Work ☐ Home ☐ Other Date_____

What was the mechanism of accident/injury? _____

When did your symptoms appear? _____ Is it constant or does it come and go? _____

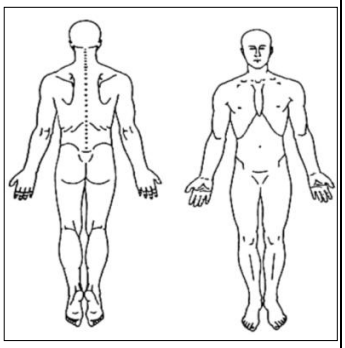
How often do you have this problem? _____ How long does the pain last? _____

Does the pain radiate? ☐ Yes ☐ No If yes, Explain: _____

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

Activities or movements that are difficult / painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



Mark an "X" on the picture where you continue to have pain, numbness or tingling.

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

(at rest) ☺ No Pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) ☹ Extreme Pain

(with activity) ☺ No Pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) ☹ Extreme Pain

What time of day is your current pain/problem worse?

☐ Morning ☐ Late in the day ☐ Middle of night ☐ As day progresses ☐ N/A

My current pain/problem seems to be:

☐ Getting better ☐ Staying the same ☐ Getting worse ☐ N/A Explain: _____

My current pain/problem can be described as (check all that apply):

☐ Electric ☐ Sharp ☐ Stabbing ☐ Knife-like ☐ Piercing ☐ Shooting ☐ Achy ☐ Griping ☐ Heavy ☐ Cramp-like

☐ Burning ☐ Deep ☐ Superficial ☐ Stiffness (am >1-2 hours or PM or Both) ☐ Spasm ☐ Tearing ☐ N/A

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ None ☐ Physical Therapy ☐ Chiropractic Care

Name of other doctor(s) who have treated you for this condition and how _____

_____

Were you satisfied with the results of your treatment? ☐ Yes ☐ No Explain how _____

_____