CONFIDENTIAL PATIENT DATA

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle Initial:	Nickname:	Date of Birth:	Sex: ❑M ❑F
Street address:	Cell Phone:	Home Phone:	
Emergency Contact Name:	Emergency Telephone #:		

INSURANCE INFORMATION

Primary Insurance:	Insured ID:
Insured Name:	Group Number:
Patient is the ❑Spouse ❑Child ❑Self ❑_____ to the insured.	Ins. Date of Birth:
Secondary Insurance:	Insured ID:

PATIENT HISTORY

Please describe your past accidents:

1.Accident: _____ ❑Job ❑Auto ❑Other Date: _____
2.Accident: _____ ❑Job ❑Auto ❑Other Date: _____
3.Accident: _____ ❑Job ❑Auto ❑Other Date: _____

Please describe your past surgeries:

1. Surgery: _____ Date: _____
2. Surgery: _____ Date: _____
3. Surgery: _____ Date: _____

Do you have any implants? ❑Yes ❑No If yes, please describe _____

Are you currently pregnant? ❑Yes ❑No

Please indicate which conditions **YOU** (the patient) have experienced by marking the boxes below.

AIDS	❑	Allergies	❑	Anemia	❑	Arthritis	❑
Asthma	❑	Back Pain	❑	Bladder Trouble	❑	Bone Fracture	❑
Cancer	❑	Chest Pain	❑	Concussion	❑	Constipation	❑
Convulsions	❑	Depression	❑	Diarrhea	❑	Dislocated Joints	❑
Epilepsy	❑	Fibromyalgia	❑	German Measles	❑	Headache	❑
Heart Trouble	❑	Hepatitis	❑	Herniated Disk	❑	High Blood Pressure	❑
High Cholesterol	❑	HIV/ARC	❑	Kidney Disorder	❑	Loss of Bowel Control	❑
Lung Disease	❑	Menstrual Cramps	❑	Migraine Headaches	❑	Multiple Sclerosis	❑
Muscular Dystrophy	❑	Neck Pain	❑	Nervousness	❑	Numbness	❑
Osteoporosis	❑	Parkinson's disease	❑	Pinched Nerve	❑	Polio	❑
Poor circulation	❑	Reproductive disorder	❑	Rheumatic Fever	❑	Rheumatism	❑
Rheumatoid Arthritis	❑	Scarlet Fever	❑	Scoliosis	❑	Serious Injury	❑
Sinus Trouble	❑	Stroke	❑	Thyroid Problems	❑	Tuberculosis	❑
Tumors or Growths	❑	Ulcers	❑	Venereal Disease	❑	_____	❑

CHOOSE YOUR SYMPTOMS FROM THE LIST BELOW.

Neck Pain	Upper Back Pain	Mid Back Pain	Low Back Pain
Left Shoulder Pain	Right Shoulder Pain	Left Hip Pain	Right Hip Pain
Left Knee Pain	Right Knee Pain	Left Leg Pain	Right Leg Pain
Stiff Neck	Headache	Left Hand Pain	Right Hand Pain

Are you willing to comply with treatment plan if necessary? YES or NO

Are you willing to comply with office policies? YES or NO

Patient's Signature: _____ Date: _____