



## ACTION CHIROPRACTIC

**CONFIDENTIAL**

### PATIENT INFORMATION

NAME: \_\_\_\_\_ S.S. # \_\_\_\_\_  
(LAST) (LEGAL FIRST) (MI)

BIRTHDATE: \_\_\_\_\_ TELEPHONE: HOME: ( ) \_\_\_\_\_

WORK: ( ) \_\_\_\_\_ CELL: ( ) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SEX: M or F MARITAL STATUS: M S D W SEP.

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

### ACCIDENT INFORMATION

Is your condition due to an accident? YES or NO

Type of accident? AUTO WORK HOME OTHER explain \_\_\_\_\_

Have you filed a report? YES or NO To whom? \_\_\_\_\_

### INSURANCE INFORMATION

INS. CO: \_\_\_\_\_

INSURED: \_\_\_\_\_

ADDRESS IF DIFF. \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

BIRTH DAY \_\_\_\_\_ S.S.# \_\_\_\_\_

GROUP #: \_\_\_\_\_ POLICY#: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare and necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit the office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. 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.

I understand that the policy set forth by Action Chiropractic requires payment in full and /or co-payment in full for all services rendered at the time of visit, unless other arrangements have been made.

PATIENTS SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SPOUSE'S OR GUARDIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**PATIENT PAIN HISTORY**

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SS#: \_\_\_\_\_

**CHIEF COMPLAINT:** NECK HEADACHES MID-BACK LOW BACK ARM SHOULDER LEG HAND

**PAIN RADIATES:** YES NO IF YES FROM: \_\_\_\_\_ TO: \_\_\_\_\_

**ONSET:** DATE \_\_\_\_\_ ONSET WAS: GRADUAL SUDDEN PROGRESSIVE OVER TIME

**HOW LONG HAVE YOU HAD THIS PROBLEM?** \_\_\_\_\_

**HAS THIS PROBLEM:** IMPROVED REMAINED THE SAME WORSENERD ON AND OFF

**IS THE COMPLAINT RELATED TO AN INJURY?** YES NO IF YES: WORK AUTO OTHER \_\_\_\_\_

**EXPLAIN** \_\_\_\_\_

**SEVERITY OF PROBLEM:** 0 1 2 3 4 5 6 7 8 9 10

(none) (little) (medium) (severe)

**DURATION OF SYMPTOMS:** INTERMITTENT (25% OF THE TIME) OCCASIONAL (25-50%)  
FREQUENT (50-75%) CONSTANT (100%)

**CHARACTER OF PAIN:** DULL/ACHE SHARP/STABBING BURNING NUMBNESS/TINGLING  
THROBBING OTHER (EXPLAIN) \_\_\_\_\_

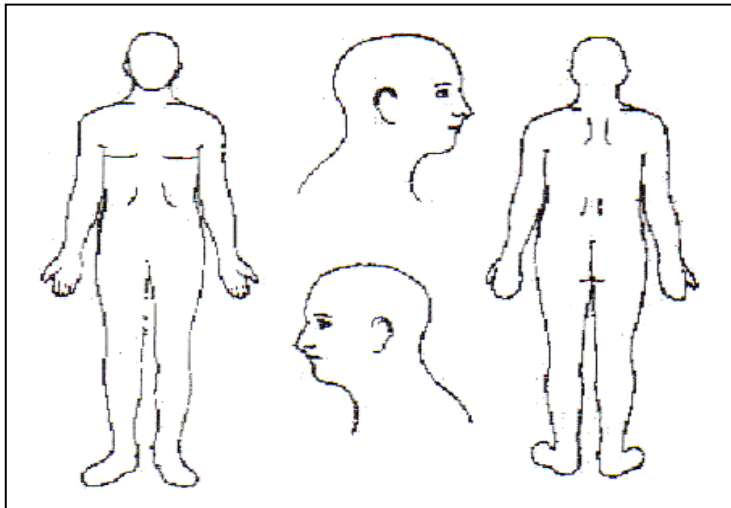
**HAS THIS PROBLEM AFFECTED:** BOWEL OR BLADDER  
OTHER BODY SYSTEMS (EXPLAIN) \_\_\_\_\_  
NO APPERANT RELATIONSHIP

**RELIEVING FACTORS:** REST EXERCISE BRACING SITTING STANDING LYING DOWN HEAT COLD  
OTHER: \_\_\_\_\_

**AGGRAVATING FACTORS:** COUGHING SNEEZING LIFTING BENDING PUSHING PULLING DRIVING

RIDING SITTING STANDING WALKING RUNNING OTHER \_\_\_\_\_

**DRAW IN YOUR PAIN**  
**PLACE AN X ON THE AREA OR**  
**AREAS THAT ARE GIVING YOU PAIN**



## HEALTH HISTORY

What treatment have you already received for this condition?

Medications  Surgery  Physical Therapy  Chiropractic Services  None  Other

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

---



---



---

Place a mark on  to indicate if you have had any of the following:

- AIDS/HIV
- Alcohol/Drug Abuse
- Anemia
- Arthritis
- Asthma
- Breathing Disorders
- Bronchitis
- Cancer
- Diabetes
- Epilepsy/Fainting/Seizures
- Fractures
- Heart Disease
- Hepatitis
- High Blood Pressure
- Kidney Disease
- Liver Disease
- Migraine Headaches
- Multiple Sclerosis
- Pacemaker
- Prostate Problem
- Psychiatric Care
- Rheumatoid Arthritis
- Stroke
- OTHER \_\_\_\_\_

### EXERCISE

None  Moderate  Daily  Heavy

### WORK ACTIVITIES

Sitting  Standing

Bending

Lifting

### HABITS

Smoking

Packs/Day \_\_\_\_\_

Alcohol

Drinks/Week \_\_\_\_\_

Coffee/Caffeine Drinks

Cups/Day \_\_\_\_\_

High Stress Level

Reason \_\_\_\_\_

### Females only:

Are you pregnant?    Yes    Due Date    No

Injuries/Surgeries you have had	Description	Date
Neck		
Low Back		
Extremities		
Other		