STANDIFER CHIROPRACTIC CLINIC

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Confidential Patient Data

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

PATIENT INFORMATION **TODAY'S DATE:** _____

NAME: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Social Security #: _____ Age: _____ ☐ Male ☐ Female E-Mail: _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Other
Name of Spouse or Nearest Relative: _____ Phone: _____
Your Occupation: _____ Your Employer: _____
Payment for Services will be by:
☐ Cash ☐ Check ☐Credit Card ☐Health Insurance ☐Automobile Insurance ☐Worker's Compensation
Name of Insurance Company: _____ Insured's Employer: _____
Insured's Social Security #: _____ Employer's Phone: _____
Are you covered by more than one insurance company? ☐ Yes ☐ No Name: _____

Please tell us why you chose **Standifer Chiropractic Clinic:** _____
_____

Referred to this Office by: ☐ Friend / Family Member ~ Name: _____
☐ Physician / Clinic ~ Name: _____ ☐ Walk-in ☐ Yellow Pages
☐ Mail ☐ Advertisement ☐ Other: _____

MEDICAL / FAMILY HISTORY (S = Self M=Mother F=Father)

[Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes]

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	Epilepsy	☐	☐	☐	Numbness
☐	☐	☐	Anemia	☐	☐	☐	German Measles	☐	☐	☐	Pollo
☐	☐	☐	Arthritis	☐	☐	☐	Headaches	☐	☐	☐	Poor Circulation
☐	☐	☐	Asthma	☐	☐	☐	Heart Trouble	☐	☐	☐	Hepatitis
☐	☐	☐	Back Pain	☐	☐	☐	Reproductive Disorders	☐	☐	☐	Rheumatic Fever
☐	☐	☐	Bladder Trouble	☐	☐	☐	High Blood Pressure	☐	☐	☐	Rheumatism
☐	☐	☐	Bone Fracture	☐	☐	☐	HIV / ARC	☐	☐	☐	Scarlet Fever
☐	☐	☐	Cancer	☐	☐	☐	Kidney Disorder	☐	☐	☐	Serious Injury
☐	☐	☐	Chest Pain	☐	☐	☐	Bowel Control Loss	☐	☐	☐	Sinus Trouble
☐	☐	☐	Concussion	☐	☐	☐	Menstrual Cramps	☐	☐	☐	Stroke
☐	☐	☐	Convulsions	☐	☐	☐	Multiple Sclerosis	☐	☐	☐	Tuberculosis
☐	☐	☐	Diabetes	☐	☐	☐	Muscular Dystrophy	☐	☐	☐	Venereal Disease
☐	☐	☐	Indigestion	☐	☐	☐	Neck Pain	☐	☐	☐	Other _____
☐	☐	☐	Dislocated Joints	☐	☐	☐	Nervousness	☐	☐	☐	Other _____

(over)

Have you been treated by a physician for any health condition in the last year? ☐ Yes ☐ No
Describe Condition: _____ Date of Last Physical Exam: _____

SURGICAL HISTORY:

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

Have you ever had a metal implant? ☐ Yes ☐ No Have you ever been gunshot? ☐ Yes ☐ No

ACCIDENT HISTORY:

☐ Job ☐ Auto ☐ Other 1. _____ Date: _____
☐ Job ☐ Auto ☐ Other 2. _____ Date: _____
☐ Job ☐ Auto ☐ Other 3. _____ Date: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Describe Your Symptoms (1-5), with 1 being MOST serious and 5 being LEAST serious:

Rate: (1-10)
1=Least ~ 10=Most

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Symptoms are worse in: ☐ Morning ☐ Afternoon ☐ Night ☐ Consistent
When and How occurred? _____

Symptoms developed from: ☐ Job Related Injury ☐ Auto Accident ☐ Other Accident—What: _____
☐ Illness ☐ Gradual Onset ☐ Unknown Cause How & Date Occurred: _____
Symptoms have persisted for # _____ Hour/s _____ Day/s _____Week/s _____Month/s ____Year/s
Symptoms / complaints: ☐ Are Constant ☐ Come and go - When: _____
Have you ever had these symptoms before? ☐ Yes ☐ No When? _____
If you were to guess, what do you think is causing your complaints? _____
Name and Location of Doctors previously seen for present condition/s:
1. Doctor: _____ Location: _____
2. Doctor: _____ Location: _____
Are you allergic to any medications? ☐ Yes ☐ No What Kind? _____
Are you taking any medicdations? ☐ Yes ☐ No What? _____
Are you pregnant? ☐ Yes ☐ No Date of last menstral period: _____
Please check the following activities that aggravate your condition: ☐ Bending ☐ Sitting ☐ Lifting
☐ Standing ☐ Lying down ☐ Turning Head ☐ Reaching ☐ Walking ☐ Other: _____
Please check any ADDITIONAL SYMPTOMS you may be experiencing: ☐ Blurred Vision ☐ Buzzing in Ears ☐ Cold Feet ☐ Cold Hands ☐ Cold Sweats ☐ Concentration Loss/Confusion ☐ Constipation ☐ Depression/ Weeping Spells ☐ Diarrhea ☐ Dizziness ☐ Face Flushed ☐ Fainting ☐ Fatigue ☐ Fever ☐ Head seems too heavy ☐ Headaches ☐ Insomnia ☐ Light bothers eyes ☐ Loss of Balance ☐ Loss of Smell ☐ Loss of Taste ☐ Low Resistance to Colds & Flu Symptoms ☐ Muscle Jerking ☐ Numbness in Fingers ☐ Numbness in Toes ☐ Pins and Needles in Arms ☐ Pins and Needles in Legs ☐ Ringing in Ears ☐ Shortness of Breath ☐ Stiff Neck ☐ Stomach Upset

Patient's Signature: _____ **Date:** _____