Chambers Chiropractic and Nutritional Healing Center

Name_____ Marital Status M S W D

Address_____ City_____ Date of Birth_____

State_____ Zip_____ How many children? _____ Age_____ Sex M F

Home Phone _____ Cell Phone_____

Email_____

Social Security # _____-_____-_____

Occupation _____ Employer_____

Employer Address_____

Name of Spouse or Parent:_____ Employer_____

If divorced situation, who has legal guardianship? _____

Parent Address _____

Spouse or Parent SS# _____-_____-_____ Spouse or Parent DOB _____

Present Family Doctor_____ Date of last physical exam_____

How did you hear about us? _____

Was this the result of an injury at:

☐ Auto ☐ Work ☐ Other Date of Injury _____

Describe injury or complaint and what you think caused it:

_____

_____

_____

Previous Chiropractic Care? ☐ Yes ☐ No

List serious accidents, falls or broken bones: _____

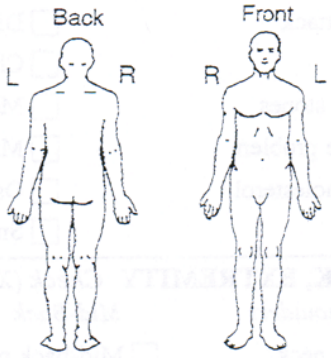
_____ When? _____

Were you ever knocked unconscious? ☐ Yes ☐ No

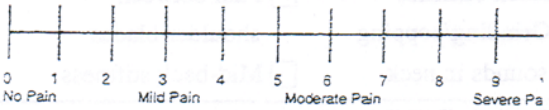
Explain:_____

_____

Mark Area of Complaint



Circle the number that best describes the level of your pai



Habits

Have you ever smoked? ☐ Yes ☐ No

Smoked _____ packs/day_____ years

Coffee _____cups per day

Sleep_____ hours a night

Exercise _____times per week

Family History

	Diabetes	Heart	Kidney	Cancer	Back
Father	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐

Insurance Information

Name of Insured_____ Relationship to Patient_____

DOB_____ Social Security #_____ Date Employed_____

Name of Employer_____ Work Phone_____

Address _____

Primary Insurance_____ Phone_____ Group_____ Employer #_____

Secondary Insurance_____ Phone_____ Group_____ Employer #_____

Massage

Have you had a professional massage before? ☐ Yes ☐ No

Was it a good experience for you? ☐ Yes ☐ No Please explain:_____

_____

What results are you looking to get out of your massage sessions?_____

_____

Is there anything that is causing you considerable concern, worry or stress in your life that may be affecting your condition?

_____

Please list the surgeries and hospitalizations that you have had and their approximate dates:

1._____ Date:_____ Doctor:_____

2._____ Date:_____ Doctor:_____

3._____ Date:_____ Doctor:_____

4._____ Date:_____ Doctor:_____

List past illness: (heart attack, thyroid, kidney, etc.)

1._____ Date:_____

2._____ Date:_____

List Allergies: (medicine, dust, ragweed, certain foods)

1._____ 2._____

3._____ 4._____

Check (x) any of the following illnesses or diseases you have or have had:

☐ Diabetes	☐ Appendicitis	☐ Chicken pox	☐ Alcoholism
☐ Cancer	☐ Scarlet Fever	☐ Tuberculosis	☐ Venereal infection
☐ Heart attack	☐ Diphtheria	☐ Whooping cough	☐ Arthritis
☐ Stroke	☐ Chronic Cough	☐ Anemia	☐ Epilepsy
☐ Kidney stones	☐ Measles	☐ Goiter	☐ Mental Disorder
☐ Prostate problem	☐ Mumps	☐ Rheumatic fever	☐ Influenza
☐ High cholesterol	☐ Osteoporosis	☐ Rheumatoid arthritis	☐ Pneumonia
☐ Polio	☐ Small pox	☐ Pleurisy	☐ Eczema

NECK, BACK, EXTREMITY *Check (X) conditions you presently have or have had in the past year.*

Neck & Shoulders	*Mid-Back*	*Arms & Hands*	*Hips, Legs & Feet*	*Low Back*
☐ Pain in neck	☐ Mid-back pain	☐ Pain down arm	☐ Pain in buttocks	☐ Low back pain
☐ Neck stiffness	☐ Pain between	☐ Pain/numbness	☐ Pain/numbness	☐ Low back stiffness
☐ Grinding/popping	shoulder blades	in hand	down leg	
sounds in neck	☐ Mid-back stiffness			

GENERAL SYMPTOMS *Check (X) conditions you presently have or have had in the past year.*

General	*Gastrointestinal*	*Eye, Ear, Nose, Throat*	*Genito-Urinary*
☐ Fever	☐ Constipation	☐ Blurred vision	☐ Blood in urine
☐ Headache	☐ Diarrhea	☐ Earache	☐ Frequent urination
☐ Migraine headaches	☐ Excessive thirst	☐ Loss of hearing	☐ Painful urination
☐ Loss of weight	☐ Stomach pain	☐ Ringing in ears	☐ Difficulty starting and/
☐ Weight gain	☐ Ulcers	☐ Nosebleeds	or stopping urine
☐ Blood in stool	☐ Dizziness		

Cardiovascular

☐ Chest pain
☐ High blood pressure
☐ Low blood pressure

Women Only

☐ Menstrual pain
☐ Abnormal bleeding

Are you pregnant? ☐ Yes ☐ No ☐ Not sure
Are you Nursing? ☐ Yes ☐ No
☐ Menopause When?

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the record any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropra insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

SIGNATURE OF PATIENT (or parent if a minor) DATE