Welcome to Village Chiropractic

Patient Information

Patient Name: _____

Address: _____

City: _____State/Zip: _____

Birth date: ___/___/____ SSN: _____

Occupation: _____

Circle One: Female/ Male

Whom may we thank for referring you? _____

Married___Single___Divorced___Widowed___

Do you have Children?___How Many?____

Patient Condition

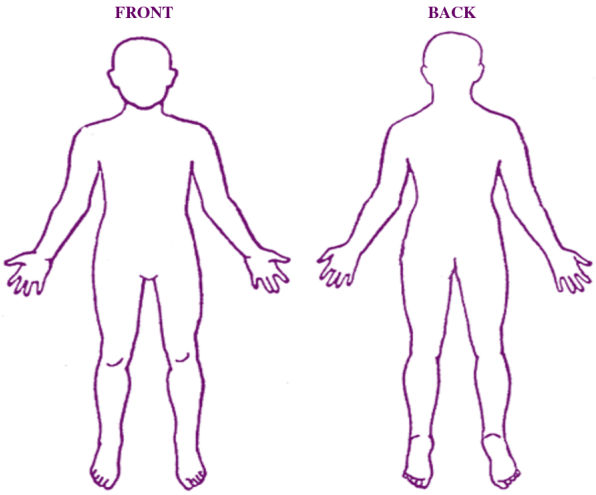
Reason for visiting: _____

When did the symptoms appear?: _____

Is this condition getting progressively worse?_____

Rate the severity of your pain on a scale from 1 to 10 (1= little pain/ 10= severe pain): _____

Mark an **X** on the picture where you have pain, numbness or tingling or any symptom.



Type of pain: ____ Sharp ____Dull ____Throbbing ____Numbness ____Aching ____Shooting ____Burning ____Tingling ____Cramps ____Stiffness ____Swelling ____Other:_____

How often do you have this pain?: _____

Is it constant or does it come and go?:_____

Does it Interfere with your:

____Daily Routine ____Sitting ____Standing ____Walking ____Bending

Phone Numbers

Cell Phone: (_____) _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Email: _____

Emergency Contact: _____

Emergency Contact #: (_____) _____

Family History

Please check any that apply to your family:

____Cancer ____Seizure ____Kidney disease ____Diabetes ____Heart Disease ____High blood pressure ____Ulcers ____Osteoarthritis ____Alcoholism ____Arthritis ____Other

Insurance Information

Who is responsible for this account?: _____

Relationship to patient: _____

Insurance Company: _____

Policy # _____

Assignment and Release

I certify that I have healthcare insurance and assign directly to Village Chiropractic all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of Patient, Parent or Guardian

_____
Please Print Name of Patient, Parent or Guardian

___/___/___ _____
Date Relationship to patient

Accident Information

Is this condition due to an accident? _____

Date of the accident: _____

Type of Accident :

____Auto ____Work ____Home ____ Other

Who have you reported this accident to?:

___Auto Ins. ___Employer ____Workers Comp

Attorney Name (if applicable)_____

Health History

What treatment have you already received for your condition?
___ Chiropractic ___ Medications ___Surgery ___Physical Therapy ___ Acupuncture

GENERAL

___ Poor Appetite
___ Heavy Appetite
___ Poor Sleep
___ Heavy Sleep
___ Insomnia
___ Bleed/Bruise Easily
___ Fatigue
___ Tremors
___ Vertigo
___ Colds Hands or Feet
___ Cold Back
___ Peculiar Taste/Smell
___ Cold Abdomen
___ Fevers
___ Chills
___ Night Sweats
___ Sweats Easily
___ Cravings
___ Chronic Infections
___ Localized Weakness
___ Poor Coordination

HEAD/FEET

___ Headaches
___ Migraines
___ Dizziness
___ Facial Pain
___ Sinus Problems
___ Blurry Vision
___ Spots in Eyes
___ Tearing/ Dryness
___ Earaches
___ Ringing in the ear
___ Poor Hearing
___ Nose Bleeds
___ Lips/ Tongue Sores
___ TMJ/Jaw Problems
___ Gum Problems
___ Teeth Grinding
___ Teeth Problems
___ Dry Mouth
___ Dry Throat
___ Hay Fever
___ Copious Saliva

HEART/LUNG

___ Pneumonia
___ Difficulty Breathing
___ Emphysema
___ Pleurisy
___ Asthma
___ Shortness of Breath
___ High Blood Pressure
___ Low Blood Pressure
___ Stroke
___ Heart Disease
___ Varicose Veins
___ Swelling of Ankles
___ Difficulty Breathing
___ Chest Pain
___ Palpitations
___ Cold Hands/ Feet
___ Heart Murmurs
___ Rheumatic Fever
___ Blood Clots

GI

___ Bad Breath
___ Constipation
___ Pain or Cramps
___ Rectal Pain
___ Bloody Stools
___ Diarrhea
___ Ulcers
___ Changes in Appetite
___ Nausea/Vomiting
___ Heartburn
___ Liver Disease
___ Hepatitis
___ Abdominal Pain
___ Kidney Disease
___ Frequent Urination
___ Impaired Urination
___ Blood in Urine

REPRODUCTIVE

FEMALE:
___ Irregular Cycles
___ Breast Lumps/Tender
___ Vaginal Discharge
___ Premenstrual Problems
___ Clotting/Bleeding
___ Menopause Difficulty
___ Painful Periods
___ Vaginal Sores

MALE:
___ Sexual Difficulties
___ Prostate Problems
___ Testicular Pain
___ Penile Discharge

SKIN/HAIR

___ Rashes/Pimples
___ Dandruff
___ Hives
___ Loss of Hair
___ Itching
___ Eczema
___ Psoriasis

NEURO

___ Seizures
___ Numbness/Tingling
___ Depression
___ Anxiety
___ Vertigo/ Dizziness
___ Loss of Balance
___ Poor Memory

ENDOCRINE

___ Hypothyroid
___ Hypoglycemia
___ Hyperthyroid
___ Diabetes
___ Night Sweats
___ Feeling Hot or Cold

LIFESTYLE

___ Alcohol
___ Tobacco
___ Marijuana
___ Drugs
How Often:_____
___ Regular Exercise
How Often:_____

DIET

___ Low Appetite
___ Coffee
___ Sugar
___ Salty Foods
___ Soft Drinks
___ Artificial Sweetener
___ Greasy/ Fried Foods

Date Of Last:
Physical Exam ___/___/____ Medical Dr Visit ___/___/____ Pregnant? ___ Yes ___ No Due Date ___/___/____

Please describe any that apply to you:
Car Accidents _____ Date ___/___/_____
Head Injuries _____ Date ___/___/_____
Broken Bones _____ Date ___/___/_____
Dislocations_____ Date ___/___/_____
Surgeries _____ Date ___/___/_____

MEDICATIONS

Drug Name	Condition Being Treated

ALLERGIES

VITAMINS