FIRST CHOICE CHIROPRACTIC
INJURY & WELLNESS CENTER
Welcomes You

Patient Information

Date _____

Patient: _____

Patient prefers to be called: _____

Address: _____

City _____ State _____ Zip _____

Northern Address: _____

City _____ State _____ Zip _____

Sex: ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS#: _____

Occupation: _____

Employer: _____

Spouse's Name: _____

I give your office permission to discuss my medical information with the following individuals:

Name _____ Relationship _____

Phone#: _____

Name _____ Relationship _____

Phone#: _____

Insurance

Primary Insurance Carrier: _____

Name of Insured (Guarantor): _____

Guarantor D.O.B. _____/_____/_____

Relationship to Patient: _____

Secondary Insurance Carrier: _____

Name of Insured (Guarantor): _____

Guarantor D.O.B. _____/_____/_____

Relationship to Patient: _____

ASSIGNMENT AND RELEASE

I, the undersigned, Certify that I or my dependent, have Insurance coverage with _____ and assign directly to Dr. _____ 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 hearby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____

Phone Numbers

Home: (___) _____ Work (___) _____ Ext_____

Cell: (___) _____

May we leave medical information on your answering machine or cell phone: ❑ Yes ❑ No

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Phone#: _____

Accident Information

Is condition due to an accident? ❑ Yes ❑ No Date _____

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Work Comp ❑ Other

Attorney Name (If applicable) _____

_____

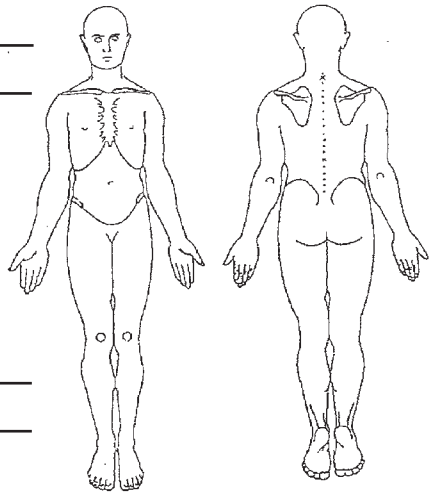
Patient Condition

Reason for visit _____

When did symptoms appear? _____

Is this condition getting progressively worse? ☐Yes ☐No ☐Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other

How often do you have this pain? _____

Is it consistent or does it come and go? _____

Does it interfere with your... ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Activities or movements that are painful to perform: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying down

Health History

What treatment have you already recieved for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____

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

_____ _____ _____

_____ _____ _____

Date of Last:

Physical Exam __/__/__ Dental X-Ray __/__/__ Chest X-Ray __/__/__ Blood test __/__/__

Spinal Exam __/__/__ Spinal X-Ray __/__/__ MRI, CT scan, Bone scan __/__/__ Urine test __/__/__

Exercise
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity
- ☐ Sitting
- ☐ Standing
- ☐ Light labor
- ☐ Heavy labor

Habits
- ☐ Smoke - pks/day_____
- ☐ Alcohol - drinks/wk _____
- ☐ Coffee/Caffeine drink - cups/day_____
- ☐ High Stress - reason_____
- ☐ OTHER_____

Are you pregnant? ☐ Yes ☐ No Due Date: __/__/__

Medications	**Allergies**	**Vitamins, Minerals, Herbs**

Injuries / Surgeries	**Date**	**Description**
☐ Falls	__/__/__	
☐ Head Injuries	__/__/__	
☐ Broken Bones	__/__/__	
☐ Dislocations	__/__/__	
☐ Surgeries	__/__/__	

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	**Emphysema**	☐ Yes ☐ No	**Migraine headaches**	☐ Yes ☐ No	**Rheumatic fever**	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	**Epilepsy**	☐ Yes ☐ No	**Miscarriage**	☐ Yes ☐ No	**Scarlet fever**	☐ Yes ☐ No
Allergy shots	☐ Yes ☐ No	**Fractures**	☐ Yes ☐ No	**Mononucleosis**	☐ Yes ☐ No	**Stroke**	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	**Glaucoma**	☐ Yes ☐ No	**Multiple sclerosis**	☐ Yes ☐ No	**Suicide Attempt**	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	**Goiter**	☐ Yes ☐ No	**Mumps**	☐ Yes ☐ No	**Thyroid problems**	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	**Gonorrhea**	☐ Yes ☐ No	**Osteoporosis**	☐ Yes ☐ No	**Tonsillitis**	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	**Gout**	☐ Yes ☐ No	**Pacemaker**	☐ Yes ☐ No	**Tumors/growths**	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	**Heart disease**	☐ Yes ☐ No	**Parkinson's disease**	☐ Yes ☐ No	**Typhoid fever**	☐ Yes ☐ No
Bleeding disorder	☐ Yes ☐ No	**Hepatitis**	☐ Yes ☐ No	**Pinched nerve**	☐ Yes ☐ No	**Ulcers**	☐ Yes ☐ No
Breast lump	☐ Yes ☐ No	**Hernia**	☐ Yes ☐ No	**Pneumonia**	☐ Yes ☐ No	**Vaginal infection**	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	**Herniated disk**	☐ Yes ☐ No	**Polio**	☐ Yes ☐ No	**Venereal disease**	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	**Herpes**	☐ Yes ☐ No	**Prostrate problem**	☐ Yes ☐ No	**Whooping cough**	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	**High cholesterol**	☐ Yes ☐ No	**Prosthesis**		**Other** _____	
Cataracts	☐ Yes ☐ No	**Kidney disease**	☐ Yes ☐ No	**Psychiatric care**	☐ Yes ☐ No	_____	
Chemical dependency	☐ Yes ☐ No	**Liver disease**	☐ Yes ☐ No	**Rheumatoid Arthritis**	☐ Yes ☐ No	_____	
Chicken pox	☐ Yes ☐ No	**Measles**	☐ Yes ☐ No			_____	
Diabetes	☐ Yes ☐ No						