

NAME _____

DATE _____

PERSONAL INFORMATION

LEGAL NAME _____

WHAT DO YOU PREFER TO BE CALLED? _____

ADDRESS _____

CITY _____ ST _____ ZIP _____

HOME PHONE # _____

WORK PHONE # _____

CELL PHONE # _____

DATE OF BIRTH _____ AGE _____

___ MALE ___ FEMALE

SS # _____

DRIVERS LICENSE # _____

EMPLOYER _____

EMPLOYER'S ADDRESS _____

MARITAL STATUS (circle one) M S D W

SPOUSE'S NAME _____

SPOUSE'S SS # _____

WHOM MAY WE THANK FOR REFERRING YOU TO

OUR OFFICE? _____

IN THE EVENT OF AN EMERGENCY

WHO SHOULD WE CONTACT?

NAME _____

RELATION _____

HOME PHONE _____

ALTERNATE PHONE _____

WELCOME

TYPE OF INSURANCE (circle one)

PPO/GROUP - MEDICARE - AUTO - WORKER'S COMP - CASH

INSURANCE NAME _____

ACCOUNT INFORMATION (if different than patient)

INSURED'S NAME _____

RELATIONSHIP _____

BILLING ADD. (if different) _____

CITY _____ ST _____ ZIP _____

HOME PHONE (if different) _____

WORK PHONE # _____

DATE OF BIRTH _____

SS # _____

DRIVERS LICENSE # _____

EMPLOYER _____

EMPLOYER'S ADDRESS _____

CONSENT TO TREAT A MINOR

I HEREBY AUTHORIZE DR. MARTIN TO ADMINISTER CHIROPRACTIC CARE AS WELL AS ANY THERAPIES DEEMED NECESSARY TO MY CHILD OR GUARDIANSHIP.

CHILD'S NAME _____

SIGNATURE (PARENT OR GUARDIAN)

_____ DATE _____

OUR OFFICE POLICY REQUIRES PAYMENT IN FULL FOR ALL SERVICES RENDERED AT THE TIME OF VISIT, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE BUSINESS MANAGER.

I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM IS COMPLETED CORRECTLY TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I HEREBY CONSENT TO TREATMENT.

SIGNATURE _____

DATE _____

NAME:

#

DATE:

PATIENT HISTORY

SURGERIES

Appendectomy__.

Back surgery__.

Cholecystectomy (gallbladder)__.

C-section__.

Dental__.

Hysterectomy__.

Knee surgery__.

Neck surgery__.

Shoulder surgery__.

Tubal ligation__.

MEDICATIONS

None__.

Advil (Ibuprofen) __.

Tylenol (acetomenifen) __.

Anti-biotics__.

Anti-depressants

ALLERGIES

None __. Animal hair __. Drugs __. Insect bites __. Seasonal __.

FAMILY HISTORY

Father: Alive __. Deceased __. Good Health __. Undetermined __. Cancer __. Diabetes __. Thyroid Disease __. Heart disease __. Kidney Disease __. Prostate __. Rheumatoid Arthritis __. Stroke __. Hypertension __.

Mother: Alive __. Deceased __. Good Health __. Undetermined __. Cancer __. Diabetes __. Thyroid Disease __. Heart disease __. Kidney Disease __. Rheumatoid Arthritis __. Osteoporosis __. Stroke __. Hypertension __.

Siblings: Good Health __. Undetermined __. Cancer __. Diabetes __. Thyroid Disease __. Heart disease __. Kidney Disease __. Prostate __. Arthritis __. Osteoporosis __. Strokes __. Birth Defects __. Hypertension __.

TOBACCO

None __. Cigarettes __. Cigar/pipe __. Smokeless tobacco __.

ALCOHOL

None __. Social __. Occasional __. Daily __.

PREVIOUS TREATMENT

None __. Primary care physician __. ER __. Orthopedic surgeon __. Neurosurgeon __. Neurologist __. Pain management __. Chiropractor __.

SOCIAL HISTORY

Single __.

Married with children __. Married without children __.

Divorced with children __. Divorced without children __.

Widowed with children __. Widowed w/o children __.

NAME:

#

DATE:

CHIEF COMPLAINT (WHAT BRINGS YOU TO THE OFFICE)

REVIEW OF SYMPTOMS (PLEASE CIRCLE CURRENT SYMPTOMS OR ILLNESSES)

GENERAL: weight loss fatigue, fever, cancer.

SKIN: rash/dyscoloration, lumps, hair loss, nail problems.

HEAD: headaches, head injuries.

EYES: redness, glasses/contacts, eye diseases.

EARS: hearing problems, ringing, pain, dizziness.

NOSE: bleeding, sinus problems.

THROAT: hoarseness, sore throat, dental diseases.

NECK: swollen glands, pain.

BREAST: lumps, discharge.

HEART: heart problems, chest pain.

LUNG: cough (blood), asthma, difficulty breathing.

ABDOMEN: heartburn, nausea, diarrhea, blood in stool, pain, constipation.

GU: genital pain, discharge, blood in urine, kidney stones, incontinence, VD, HIV-positive.

FEMALE: painful periods.

MALE: prostate problems.

MUSCULOSKELETAL: joint pain, muscle pain, arthritis, joint swelling.

VASCULAR: color changes, cold hands or feet.

NEURO: fainting, seizures, numbness/tingling, memory loss, stroke.

PSYCHOLOGICAL: depression, mood swings.

ENDOCRINE: thyroid, diabetes, osteoporosis, hormone replacement, excessive urination.

HEMATOLOGIC: anemia, bleeds easy.