

# 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 \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Age: \_\_\_\_\_  Male  Female

Marital Status:  Married  Single  Divorced  Separated  Other \_\_\_\_\_

Name of Spouse or Nearest Relative: \_\_\_\_\_ Phone: \_\_\_\_\_

Your Occupation \_\_\_\_\_

Your Employer: \_\_\_\_\_

Referred to this Office by:  Friend/Family Member - Name? \_\_\_\_\_

Yellow Pages  Mail  Clinic Location  Other \_\_\_\_\_

Payment for Services will be by:  Cash  Check  Credit Card  Health Insurance

Automobile Insurance  Worker's Compensation

Name of Insurance Co.: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

Are you covered by more than one insurance company?  Yes  No

Name \_\_\_\_\_

**MEDICAL/FAMILY HISTORY** S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	venereal disease

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      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 Rate Your symptoms(1-10) See "Rate Symptoms chart

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

SYMPTOMS ARE WORSE IN  MORNING  AFTERNOON  NIGHT

WHEN AND HOW OCCURRED? \_\_\_\_\_

SYMPTOMS DEVELOPED FROM:  JOB RELATED INJURY  AUTO ACCIDENT  OTHER  ACCIDENT  
 ILLNESS  UNKNOWN CAUSE  GRADUAL ONSET DATE OCCURRED: \_\_\_\_\_

SYMPTOMS HAVE PERSISTED FOR # \_\_\_\_ HOUR(S) \_\_\_\_ DAY(S) \_\_\_\_ WEEK(S) \_\_\_\_ MONTH(S) \_\_\_\_ YEAR(S)

SYMPTOMS/COMPLAINTS:  COME & GO  ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE:  NO  YES 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):  
\_\_\_\_\_  
\_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATIONS  NO  YES WHAT KIND? \_\_\_\_\_

ARE YOU TAKING ANY MEDICATIONS  NO  YES WHAT KIND? \_\_\_\_\_

ARE YOU PREGNANT  NO  YES DATE OF LAST MENSTRUAL PERIOD \_\_\_\_\_

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:**

BENDING  REACHING  STRAINING AT STOOL  COUGHING  SITTING  TURNING HEAD  
 LIFTING  SNEEZING  WALKING  LYING DOWN  STANDING

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:**

BENDING  SITTING  LIFTING  STANDING  LYING DOWN  TURNING HEAD  REACHING  
 WALKING

**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  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

**Note:** It is understood and agreed that the amount paid Greater Lansing Chiropractic Center for X-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen while a patient of this office.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

To avoid bookkeeping expense, payment is expected at the time service is rendered unless other arrangements are made