

# 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: \_\_\_\_\_

Social Security #: \_\_\_\_\_ 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 Social Security #: \_\_\_\_\_ Employer's Phone #: \_\_\_\_\_

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 dis

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.