**CONFIDENTIAL PATIENT INFORMATION** **TODAY'S DATE:** _____

Name:_____ DOB:____/____/____ Age:____

Address:_____

SS#:_____ Home Phone(____)_____ Work Phone: (____)_____

Cell phone: (  ) _____ Email:_____

Marital Status: M S D W How Many Children?_____ Ages_____ _____ _____ _____

Occupation:_____Employer Address:_____

Name of Spouse: _____ Occupation:_____

Work Address: _____ Work Phone: (____)_____

Patient's Nearest Relative: _____ Home Phone: (____)_____

Referred by: _____

Family Physician: _____ Phone:(____)_____Address:_____

Date of Last Physical Examination: _____

What operations have you had? _____

Any Serious Illnesses? _____

Have you been treated for any health condition in the past year? Yes____ No ____ Describe: _____

_____

**Would you like a report of your Chiropractic exam and treatment recommendations sent to your family Physician? Yes___ No____**

What medications are you taking, including vitamins? _____

_____

Purpose of this appointment: _____

When did this condition begin? _____

Other Doctors seen for this condition:_____

**IF YOURS IS AN ACCIDENTAL INJURY PLEASE LET US KNOW SO THAT YOU CAN COMPLETE AN ACCIDENT FORM.**

Remarks and additional information: _____

_____

Name of person responsible for payment: _____ Relationship to patient: _____

Are you insured? Yes _____ No _____ Insurance Company: _____

Policyholder's name: _____ Relationship to patient: _____

ID# _____ Group #: _____

Address: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Downingtown Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Downingtown Chiropractic Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I am aware that should I not give 24 hour notice for a missed massage appointment, I will be responsible for $30.00 payment to Downingtown Chiropractic Center. I am also aware that should I not give 24-hour notice for missed chiropractic appointments I will be responsible for a payment to Downingtown Chiropractic Center. I further agree that should suit be brought against me to collect outstanding charges, I will pay all collection costs, including attorney fees and court costs incurred by Downingtown Chiropractic Center. I am aware that 1% interest will be charged to past due notices. I consent to treatment as deemed necessary by the attending doctor, nurse or qualified designate.

Patient's Signature: _____ Date: _____

Parent or Guardian if patient is under 18: _____ Date: _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. These questions, however, must be answered carefully as these problems can affect your overall course of chiropractic care.

## CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

☐ Pneumonia ☐ Mumps ☐ Influenza ☐ Rheumatic Fever ☐ Small Pox ☐ Anemia
☐ Chicken Pox ☐ Arthritis ☐ Lumbago ☐ Tuberculosis ☐ Epilepsy ☐ Cancer
☐ Measles ☐ Thyroid ☐ Pleurisy ☐ Polio ☐ Eczema ☐ Heart Disease
☐ Mental Disorder ☐ Whooping Cough ☐ Diabetes

**Intake:** ☐ Coffee ☐ Tea ☐ Alcohol ☐ Cigarettes ☐ White Sugar

## CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST SIX MONTHS:

**MUSCO-SKELETAL:**
☐ Low back pain ☐ Pain between shoulder blades ☐ Neck pain ☐ Arm pain
☐ Joint pain/stiffness ☐ Difficulty chewing/clicking jaw ☐ Walking problems ☐ General stiffness

**NERVOUS SYSTEM:**
☐ Nervousness ☐ Numbness ☐ Paralysis ☐ Dizziness ☐ Fainting ☐ Convulsions ☐ Stress
☐ Forgetfulness ☐ Cold/tingling extremities

**GENITO-URINARY:**
☐ Bladder trouble ☐ Painful/excessive urination ☐ Discolored urine

**GENERAL:**
☐ Fatigue ☐ Allergies ☐ Loss of sleep ☐ Fever ☐ Headaches

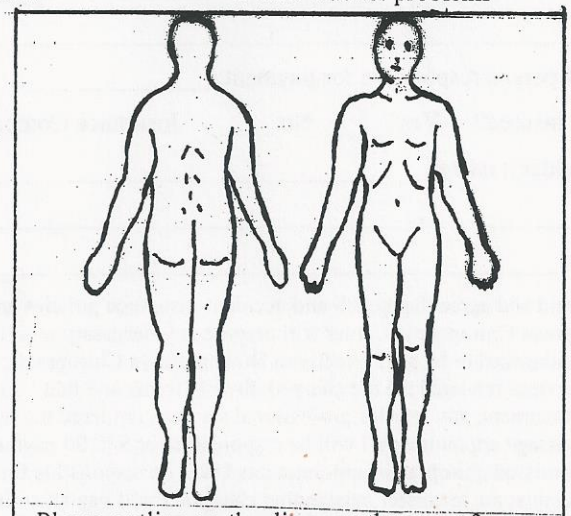
**CVR:**
☐ Chest pain ☐ Shortness of Breath ☐ Blood pressure problems ☐ Irregular heartbeat
☐ Stroke ☐ Heart problems ☐ Varicose veins ☐ Ankle swelling
☐ Congestion/lung problems

**EENT:**
☐ Vision problems ☐ Dental problems ☐ Sore throat ☐ Ear aches ☐ Stuffed nose ☐ Hearing difficulty

**GASTRO-INTESTINAL:**
☐ Poor/excessive appetite ☐ Excessive thirst ☐ Frequent nausea ☐ Vomiting ☐ Diarrhea ☐ Heartburn
☐ Abdominal cramps ☐ Hemorrhoids ☐ Liver problems ☐ Weight Trouble ☐ Colitis
☐ Black/bloody stool ☐ Constipation ☐ Gas/bloating after meals ☐ Gall bladder problems

**FEMALE:**
☐ Menstrual Irregularity
☐ Menstrual Cramping
☐ Vaginal Pain/Infections
☐ Breast Pain/Lumps
When was your last period?_____
Are you pregnant?_____
Due Date: _____

**MALE:**
☐ Urinary Frequency ☐ Prostate/Sexual Dysfunction



Please outline on the diagram, the area of your discomfort. Use the following codes:

| | |
|---|---|
| Pins and Needles | ooooo |
| Numbness: | ------- |
| Burning: | xxxxx |
| Aching: | ***** |
| Stabbing: | //////// |