Confidential Patient Information

Date _____

Name _____ SSN _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____Fax _____ Cell Phone _____

Age ____ Birth Date _____Height_____ Weight_____ Marital Status: M S W D # of Children_____

Occupation _____ Employer _____

Employer Address _____Office Phone _____

Spouse _____ Occupation _____ Employer _____

Emergency Contact _____ Phone _____Address_____

Family Medical Doctor _____Clinic _____ Phone _____

Insurance Co._____Policy #_____

Name on Policy (if not self)_____ Is this a Group or Individ. Plan_____

Insured's Birth Date_____ Insured's SSN_____

Do you now or have you ever suffered from:

GENERAL:
___ Allergies_____
___ Convulsions
___ Dizziness/Fainting
___ Headaches
___ Numbness/Tingling

CARDIOVASCULAR:
___ High Blood Pressure
___ Low Blood Pressure
___ Hardening Arteries
___ Chest Pain
___ Rapid/Slow Pulse
___ Poor Circulation
___ Swelling/Edema
___ Anemia

MUSCLE & JOINT:
___ Arthritis
___ Bursitis
___ Foot Trouble
___ Low Back Pain
___Neck Pain/Stiffness
___ Pain between Shoulders
___Sciatica
___ Shoulder Pain
___ Elbow/Wrist/Hand Pain
___ Hip Pain
___ Leg Pain
___ Knee Pain
___ Jaw Pain/TMJ
___ Cancer _____

GASTRO-INTESTINAL:
___ Constipation
___ Diarrhea
___ Gall Bladder Trouble
___ Liver Disease
___ Hemorrhoids
___ Heartburn/Indigestion
___ Hernias

EYE/EAR NOSE/THROAT:
___ Colds/Sinus Infection
___ Earache/Ringing
___ Nosebleeds
___ Eye Pain

Mental Illness:
_____

RESPIRATORY:
___ Asthma
___ Chronic Cough
___ Shortness of Breath
___ Spitting up Blood
___ Spitting up Phlegm
___ Wheezing

GENITO-URINARY:
___ Kidney Disease
___ Bed Wetting
___ Infertility
___ Urgency/Frequent/ Painful Urination
___ Prostate Disease
___ Diabetes

FEMALE PATIENTS:
___ Cramps or Backache ___ Painful/Excessive Menstration ___ Menopausal Symptoms/ Hotflashes

PLEASE LIST YOUR CURRENT AREAS OF COMPLAINT:
(chief complaint)

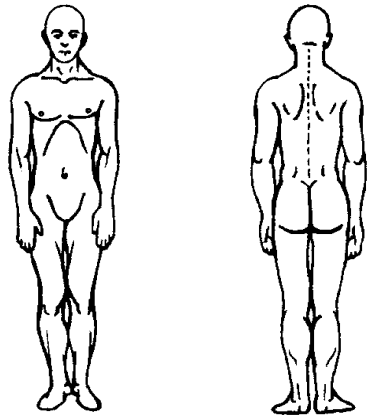
1) _____ 2) _____ 3) _____ 4) _____

0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10

CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN: 1 = Mild, 10 = Severe

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

Dull	= D
Aching	= A
Stiffness	= S
Burning	= B
Tingling	= T
Numbness	= N
Sharp	= !!!
Shooting	= XXX
Other_____	= ***



How often do you notice your symptoms? Constantly Frequently Occasionally

Does anything provide relief?_____

What activities are difficult to perform? (Circle applicable) Standing Sitting Lying Down Walking Bending

Lifting Steps Twisting Other: _____

Please describe any other activities that are restricted?_____

When did you first notice these symptoms?_____ Is the condition getting worse? No Yes

Have you had this problem before? No Yes

When?_____

Have you had an injury, fall or accident? No Yes

Describe_____

Have you ever been to a Chiropractor before? No Yes How was your experience? _____

Have you had x-rays before? No Yes When? _____ What areas?_____

I am currently taking the following medications/supplements for the following reasons: None

_____

Have you had any broken bones in the past?_____

Surgical History: _____ None

Serious Illnesses (Include dates)_____

Have you been treated for any health conditions in the past year? Yes____ No___ Describe_____

Which best describes your health goals: pain relief only correct entire problem wellness/ preventative care

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Have you or a family member been diagnoses with any of the following conditions:

____Heart Disease ____Cancer ____Diabetes ____High Blood Pressure

____Stroke ____Other_____

AUTHORIZATION & RELEASE:

I have answered the above questions to the best of my knowledge and understand that providing inaccurate information is dangerous to my health.

I also authorize payment of insurance benefits directly to Dr. Jason Grimm or Nevada Family Chiropractic Inc. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that I am personally responsible for payment of all services, which are rendered to me that my insurance company does not pay. I also understand that if I suspend or terminate my care and my treatment, any fees for professional services, which are rendered to me, will be immediately due and payable. Should my account become delinquent, I will be responsible for any interest (to accrue at the rate of 18% annually, commencing 30 days after the initial bill for services is issued), for collection fees, including but not necessarily limited to attorneys fees and court costs incurred in collection attempts on my account. I hereby authorize Nevada Family Chiropractic to release any information to my insurance company/attorney acquired in the course of my examination or care. I understand that a photocopy of the above assignment and authorization will be deemed as valid as the original.

PATIENT/GUARDIAN SIGNATURE_____

DATE_____

Our goal is to bring better health to our community. The best way for us to reach others is through word of mouth & satisfied patient referrals. The greatest compliment a patient can give is a referral of friends and family.

How did YOU hear about our office or whom may we thank for your referral?

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