TRUEHEALTH FAMILY CHIROPRACTIC

PATIENT INFORMATION

Patient Name _____
Last Name

_____
First Name Middle Initial

Sex ❑M ❑F Age_____ Date of Birth_____
❑Married ❑Widowed ❑Single ❑Minor ❑Separated
❑Divorced ❑Partnered for _____ years

Address _____

City _____

State _____ Zip _____

Home Phone (_____)_____

Cell Phone (_____)_____

E-mail_____

Employer / School_____

Occupation _____

Employer / School Phone (_____)_____

Spouse's Name _____

Spouse's Employer_____

IN CASE OF EMERGENCY, CONTACT

Name _____Relationship_____

Home Phone (_____)_____ Work Phone (_____)_____

Whom may we thank for referring you?

_____

PATIENT CONDITION

Reason for Visit: ❑ Spinal and Nervous System Check-up

❑ Other: _____

If there is a symptom, when did your symptom appear? _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____

Type of pain: ❑Sharp ❑Dull ❑Throbbing ❑Numbness ❑Aching ❑Shooting ❑Burning ❑Tingling
❑Cramps ❑Stiffness ❑Swelling ❑Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation
Activities or movements that are painful to perform: ❑Sitting ❑Standing ❑Walking ❑Bending ❑Laying Down

INSURANCE INFORMATION

Insurance Co. _____

ID # _____

Subscriber's Name _____
Is Patient covered by additional insurance? ❑ Yes ❑ No

If YES, List Additional Insurance _____

ACCIDENT INFORMATION

Is this consultation due to an accident? ❑No ❑Yes

If so, what was the date of Accident: _____

Type of accident ❑Auto ❑Work ❑Home ❑Other
To whom have you made a report of your accident?

_____

Claim number: _____
❑Auto Insurance ❑Employer ❑Worker Comp. ❑Other

Attorney Name (if applicable) _____

Address _____

_____ (_____)_____
Phone

HEALTH HISTORY

What health care have you already received for your condition?

❑ Chiropractic Care (Dr. _____ Date_____) ❑ Surgery (Dr. _____ Date_____)

❑ Medications (Dr. _____ Date_____) ❑ Physical Therapy (Dr. _____ Date_____)

❑ Other: _____ (Dr. _____ Date_____)

❑ None

Place a mark in the box to indicate if you have had any of the following:

❑Headaches
❑Nervousness
❑Insomnia
❑Head colds
❑High blood pressure
❑Migraines
❑Nervous breakdown
❑Chronic tiredness
❑Dizziness
❑Sinus troubles
❑Eye problems
❑Pacemaker
❑Ear ache
❑Ulcers
❑Stomach troubles
❑Indigestion
❑Heartburn
❑Depression
❑Lowered resistance
❑Diabetes
❑Mental conditions

❑Convulsions
❑Acne
❑Eczema
❑Hay Fever
❑Adenoids
❑Hearing loss
❑Ringing ear
❑Laryngitis
❑Hoarseness
❑Sore throat
❑Tonsillitis
❑Croup
❑Poor circulation
❑Swollen ankles
❑Cold feet
❑Weakness in legs
☑Leg cramps
❑Hemorrhoids (piles)
❑Bursitis
❑Thyroid condition
❑Asthma

❑Cough
❑Difficult breathing
❑Shortness of breath
❑Heart condition
❑Bronchitis
❑Pleurisy
❑Pneumonia
❑Congestion
❑Influenza
❑Gall bladder condition
❑Jaundice
❑Shingles
❑Liver condition
❑Fever
❑Low blood pressure
❑Arthritis
❑Kidney troubles
❑Constipation
❑Colitis
❑Dysentery
❑Diarrhea

❑Ruptures
❑Hernias
❑Cramps
❑Varicose veins
❑Bladder troubles
❑Menstrual problems
❑Miscarriages
❑Bed wetting
❑Impotency
❑Change of life symptoms
❑Knee pain
❑Sciatica
❑Difficult urination
❑Painful urination
❑Frequent urination
❑Other
_____
_____

EXERCISE

❑ None
❑ Moderate
❑ Daily
❑ Heavy

WORK ACTIVITY

❑ Sitting
❑ Standing
❑ Light Labor
❑ Heavy Labor

HABITS

❑ Smoking Packs/Day _____
❑ Alcohol Drinks/Week _____
❑ Coffee/Caffeine Drinks Cups/Day _____
❑ High Stress Level Reason _____

PREGNANCY

Are you currently pregnant? ❑No ❑Yes, and I am due _____ Number of past pregnancies _____

Children's Ages: Child #1 _____ Child #2 _____ Child #3 _____ Child #4 _____

Injuries/Surgeries you have had:	Description	Date
Falls		
Head Injuries		
Broken Bones/Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____
_____

ALLERGIES

_____
_____
_____
_____

SUPPLEMENTS

_____
_____
_____
_____