Chiropractic Family Health Center
Confidential Patient Health Information – New Episode

Patient Name: _____ **Height** _____ **Weight** _____

Today's Date: _____ **Rate your pain:** 1 2 3 4 5 6 7 8 9 10
(circle based on what applies RIGHT NOW)

What happened?
Did something specific cause your pain? : _____

Reason for visit: Neck Shoulder Upper- Back Mid-Back Low-Back Hip Knee Foot Other _____

Symptoms began: ____/____/____
Month/day/year

Symptom frequency/How often do you feel this (Circle one)
Constant (75%-100% of awake time) Frequent (51%-75% of awake time)
Intermittent (26%-50% of awake time) Occasional (0%-25% of awake time)

Type of Pain: Dull Tight Pinching Dull Pins & Needles Shooting Deep Tender
(Circle all that apply) Achy Burning Sharp Stabbing Throbbing Sore

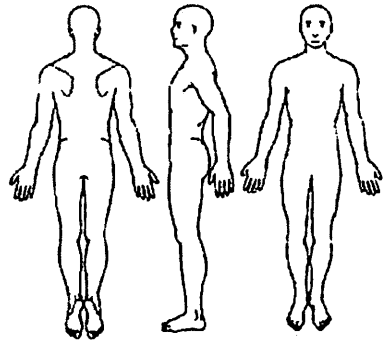
Worse during: Morning afternoon night Changes with weather **OR** doesn't change with weather

What helps *relieve* symptoms: Ice Heat Medication Nothing helps Other _____

Activities limited by discomfort: (circle those that apply)

Bending
Bowel Movements
Coughing
Daily Routine
Driving
Getting up
Lifting
Lying Down
Pulling
Reading
Sitting
Sleeping
Sneezing
Standing
Turning my head
Urination
Walking
Working
Recreation
Pushing
Other

mark below where your pain is felt



Tried other medical treatments for this condition? **No** **Yes** **explain:**_____

Is the discomfort the result of an accident? **No** **Yes** **explain:**_____

Current Medications:

_____
_____
_____
_____

Surgeries (include year in brackets)**:**

_____
_____
_____
_____

We appreciate referrals and we like to thank and reward those who refer others to come in for care.

If you were referred you to our office, please tell us who referred you. _____

Did you find us with an online search or using a smartphone app? NO YES _____

Chiropractic Family Health Center

CONFIDENTIAL PATIENT INFORMATION FORM – PLEASE PRINT

Last Name _____ First Name _____ Middle Initial _____ Date _____

Home Address _____ City _____ State _____ Zip Code _____

Billing Address (if different than above): _____

Home Phone _____ Cell Phone _____

E-Mail _____ Best time to reach you _____

Date of Birth _____ Sex: Male Female

Social Security #: _____ Current Smoking Status: NO YES year started _____

Occupation _____ Employer Name _____

Employer Address _____

Office Phone _____ May we contact you at this number? Yes No

Do you have insurance? Yes No ***If you would like for us to file your claim, please give your insurance card to the front office staff to be copied, and we will call to verify your benefits.***

Marital Status: S M D W Spouse's name _____ Spouse's DOB: _____

Date of last physical exam _____ Doctor's name _____

List all broken bones / dislocations / major dental work/ bone or joint replacements (include years in brackets)

_____

_____

Person to contact in case of emergency _____

Address _____ Phone _____

Name of closest relative not living with you _____

Address _____ Phone _____

Person responsible for account _____ Relationship to patient _____

The statements made on this form are accurate to the best of my recollection. I understand and accept that there are risks associated with chiropractic care and give my consent for Chiropractic Family Health Center to provide services to me and/or my family. I understand that there is a fee for services and that fees are payable at the time services are rendered. I hereby agree to such fees and understand that I am liable for any and all legal fees and/or reasonable interest if collection services become necessary.

Responsible Party/Patient _____ Date _____