Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Patient Information:

Today's Date:___________

Name:____ Date of Birth:_________________

SSN#:___________________ Driver License#:______________ Age:_______ ☐ Female ☐ Male

Address:______________________________ City:_______________ State:______ Zip:__________

Home#:___________________ Cell#:__________________ E-mail:___________________________

Preferred Method of Contact: ☐ Home# ☐ Cell# ☐ E-mail

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Other_________________

Name of Spouse or Nearest Relative:_________________________ Phone#:__________________

Number of Children:________ Ages of Children: _____,______, _____, _____, _____, _____

Your Occupation:________________________ Your Employer :________________________________

Weight Frequently Required to Lift: <10 lb <20 lb <30 lb <40 lb other______

Referred to Schumacher Chiropractic by:

☐ Yellow Pages ☐ Direct Mail ☐ Ins. Directory ☐ Health Talk:____________

☐ Billboard ☐ Newspaper ☐ Internet/Website ☐ Screening:_____________

☐ Friend:_______________________ ☐ Doctor:__________________________

Payment for Services will be made by:

○ Cash ○ Credit Card ○ Workers Compensation

○ Check ○ Health Insurance ○ Automobile Insurance

Health Insurance Information

Name of Insured:___________________________________ Insured's Date of Birth:_______________

Name of Insurance Co:_____________________________ Insured's Social Security #:______________

Insured Employer:_____________________________ Employer's Phone# :___________________

Are you covered by more than one insurance company?

☐ Yes, __________________________________ ☐ Supplement ☐ Secondary

☐ No

Medical Family History S = Self M = Mother F = Father

(Indicate which conditions have been experienced by you or parents by marking the space)

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	dislocated joints	☐	☐	☐	neck pain
☐	☐	☐	allergy	☐	☐	☐	epilepsy	☐	☐	☐	nervousness
☐	☐	☐	anemia	☐	☐	☐	German measles	☐	☐	☐	numbness
☐	☐	☐	arthritis	☐	☐	☐	headaches	☐	☐	☐	polio
☐	☐	☐	asthma	☐	☐	☐	heart trouble	☐	☐	☐	poor circulation
☐	☐	☐	back pain	☐	☐	☐	reproductive disorders	☐	☐	☐	hepatitis
☐	☐	☐	bladder trouble	☐	☐	☐	high blood pressure	☐	☐	☐	rheumatic fever
☐	☐	☐	bone fracture	☐	☐	☐	HIV/ARC	☐	☐	☐	rheumatism
☐	☐	☐	cancer	☐	☐	☐	kidney disorder	☐	☐	☐	scarlet fever
☐	☐	☐	chest pain	☐	☐	☐	bowel control loss	☐	☐	☐	serious injury
☐	☐	☐	concussion	☐	☐	☐	menstrual cramps	☐	☐	☐	sinus trouble
☐	☐	☐	convulsions	☐	☐	☐	multiple sclerosis	☐	☐	☐	tuberculosis
☐	☐	☐	diabetes	☐	☐	☐	muscular dystrophy	☐	☐	☐	venereal disease
☐	☐	☐	indigestion	☐	☐	☐	fibromyalgia	☐	☐	☐	other:____________________

Have you been treated by a chiropractor before? ☐ Yes ☐ No
Name/Location:____
Have you been treated by a physician for any health condition in the last year? ☐ Yes ☐ No Describe
Condition:____
Date of last Physical Exam:_________________
Are you allergic to any medications? ☐ Yes ☐ No List:_______________________________________
Are you taking any medications? ☐ Yes ☐ No
List:____
Are you taking any vitamins? ☐ Yes ☐ No
List:____
Are you pregnant? ☐ Yes ☐ No Date of last Menstrual Period:_________________
Date of last Pap Smear:__________________

Surgical History

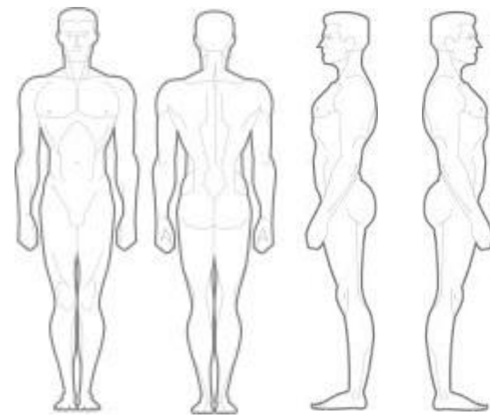
1)____ Date:______________
2)____ Date:______________
3)____ Date:______________

Have you ever had a metal implant? ☐ Yes ☐ No
Have you ever been gunshot? ☐ Yes ☐ No

Accident History

Work Auto Sport 1)___________________________ Date:______________
Work Auto Sport 2)___________________________ Date:______________
Work Auto Sport 3)___________________________ Date:______________

Current Health Concern Information



(Please indicate the location of your complaint above)

Present major complaints:

1)______________________________________

2)______________________________________

3)______________________________________

4)______________________________________

Which of your complaints bother you most?

□ 1 □ 2 □ 3 □ 4

Symptoms Developed From:

□ job related injury If so, did you report it to your employer? □ Yes □ No

□ auto accident □ injury □ illness □ unknown cause □ gradual onset □ other

How Occurred? ____

____

Date Occurred:__________________

Symptoms have persisted: ____hour(s) ____day(s) ____week(s) ____month(s) ___year(s)

Do you have numbness or tingling radiating down your: □ arms □ hands □ legs □ feet

Symptoms/Complaints: □ come & go □ are constant □ getting worse □ getting better

Symptoms are worse in: □ morning □ afternoon □ evening

Please check all activities that AGGRAVATE your condition:

□ bending □ reaching □ bowel movement □ coughing □ sitting □ turning head

□ lifting □ sneezing □ lying down □ walking □ standing

Please check all activities that RELIEVE your condition:

□ rest □ stretches □ standing □ movement □ walking □ heat □ massage/TP

□ ice □ adjustments

Have you ever had this before? □ Yes □ No When?_____________________________________

Name and location of doctors previously seen for present condition :____________________________

____

Outcome of treatment:____

When its at its worst, how does your condition interfere with your normal activities?________________

____

Does this condition reduce your productivity or effectiveness at work? □ Yes □ No

Does it create any problems in your relationship? □ Yes □ No

If your problem was left untreated for 5 years, how do you think it would affect you?________________

____

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

□ blurred vision	□ buzzing/ringing in ears	□ cold feet	□ cold hands
□ low resistance to colds	□ concentration loss	□ constipation	□ depression
□ light sensitivity of eyes	□ heavy menstruation	□ irregular cycles	□ fainting
□ numbness in fingers	□ numbness in toes	□ headaches	□ insomnia
□ shortness of breath	□ frequent urination	□ dizziness	□ fever
□ pins/needles in arms/legs	□ painful urination	□ stomach upset	□ diarrhea
□ indigestion/heartburn	□ pain between shoulders	□ muscle jerking	□ stiff neck
□ loss of balance	□ loss of smell	□ loss of taste	□ face flushed

Physical/Emotional/Chemical Stress Test

The following areas of stress can cause misaligned vertebrae (subluxation).
Which of these stresses do you feel are affecting your health? Check all that apply:

☐ Birth trauma	☐ Slips/Falls	☐ Auto accident(s)	☐ Sports injury
☐ Physical abuse	☐ Poor posture	☐ Extensive computer work	☐ Work injuries
☐ Sleeping on couch	☐ Sitting on wallet	☐ Repetitive lifting/bending	☐ Driving long hours
☐ Continuous sitting	☐ Relationship stress	☐ Concealed feelings	☐ Quick Tempered
☐ Smoker	☐ 2nd hand smoke	☐ Poor diet/excessive sugar	☐ Caffeine
☐ Artificial sweetener	☐ Prescription drugs	☐ Over the counter drugs	☐ Pollution/vapors

What do you feel are the major stressors on your health?____

How would you rate your stress level? (low) 1 2 3 4 5 6 7 8 9 10 (high)

Do you worry about someone else's health? ☐ Yes ☐ No Who?___________________

Please tell me about your children____

____

Name of Primary Cary Physician:____

Location:____

Phone Number:______________________________

Wellness Profile

Are you committed to eliminating not only your symptoms, but what caused them, even if it requires a change in your lifestyle? ☐ Yes ☐ No

Chiropractic care affects more than just your muscles and bones. What health goals do you hope to find for yourself? Check all that apply

☐ more energy	☐ better sleep	☐ freedom from pain
☐ easier breathing	☐ balanced posture	☐ improved nutrition
☐ improved coordination	☐ improve overall health	☐ reduce medications
☐ better sports performance	☐ better concentration	☐ enhanced emotional well-being
☐ high resistance to disease	☐ relief from symptoms	☐ other__________________________

By signing below I hereby certify that my health information is complete and accurate to the best of my ability.

Patient Signature:___________________________________ Date :____________________

Guardian Signature :_________________________________ Relationship:____________________

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Accept patient for treatment ☐ Yes ☐ No

Doctor Signature:____