GOVERNOR'S PARK CHIROPRACTIC

Welcome to Our Office

Beginning chiropractic care is the first and most important step on your journey towards good health. Please answer all questions on this form completely and honestly. This information will help your doctor of chiropractic determine the best treatment plan for your condition. If you have any questions concerning this form or your future care with our office, please do not hesitate to ask any of our staff members.

Contact Information

Patient Name _____ Female Male

Date of Birth _____ Age _____ Social Security # _____-_____-_____

What would you prefer to be called? _____ Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip Code _____

Email Address _____

Marital Status: Single Married Divorced Separated Widowed Spouse's Name _____

Employer _____ Position/Job Duties _____

I would like the following person to have access to ___ my complete medical record ___ other. Name _____

Emergency Contact Information

Name _____ Home Phone _____

Relationship to You _____ Work Phone _____

Referral Information

We would like to personally thank the person, physician, or attorney who referred you to our office.

Existing Patient My Physician My Attorney My Insurance Internet Other: _____

Her/His Name _____ Phone Number _____

Address _____ City _____ State/Zip _____

Billing Information

Person Ultimately Responsible for Account: _____

Relationship to Patient: Self Parent Legal Guardian Other: _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

Social Security # _____-_____-_____ Driver's License _____ State _____

Employer _____ Work Address _____

Insurance Company _____ ID # _____

Primary Insured's Name _____ Relationship to Patient _____

Address _____ Cell Phone _____

City _____ State _____ Zip Code _____ Date of Birth _____

Primary Insured's ID # _____ Primary Insured's SS_____-_____-_____

Our policy requires payment in-full for all services rendered at the time of your visit, unless other arrangements have been made with our office manager. Your signature below shows that you understand and agree to our financial policy and that you authorize our staff to perform any necessary services needed during diagnosis and treatment.

Signature _____ Date _____

Health History

Patient Name _____ Date _____

Primary Care Physician _____ Phone _____

Address _____ Fax _____

City _____ State _____ Zip Code _____

Do you have x-rays? Yes [Date _____] No Do you have other films (ie MRI)? Yes [Date _____] No

We would like to remain in contact with your primary care physician and specialists, as required, during your course of treatment with our clinic to help improve the continuity and quality of your care. This contact will include phone calls and the delivery of reports or films to your PCP as needed. This release can be canceled or limited at any time in writing. Your signature below shows that you understand and agree with our request.

Signature _____ Date _____

Are you currently seeing any specialists in addition to your PCP? No Yes (Please list names & addresses below)

Physician's Name Specialty Address

_____

_____

Current Medications/Supplements Reason for Taking Prescribing Doctor Dosage

_____

_____

Previous Surgeries Reason Surgeon Date

_____

Please list all known allergies (include food allergies): _____

_____

Previous Serious Accidents and Injuries (auto, work-related, falls, etc.): _____

_____

Height _____ Weight _____ Left or Right Handed? _____

Have you or an immediate family member ever experienced any of the following diseases or medical conditions?

C – current medical condition **P** – past medical condition **F** – immediate family member

Respiratory and Cardiovascular

____ Difficulty Breathing ____ Asthma ____ Sinus Problems ____ Chest Pain
____ High/Low Blood Pressure ____ Congenital Heart Defect. ____ Heart Murmur ____ Heart Attack
____ Anemia ____ Stroke ____ Other _____

Musculoskeletal

____ Severe/Freq. Headaches ____ Broken Bones ____ Frequent Neck Pain ____ TMJ Syndrome
____ Muscle Sprain/Strain ____ Lower Back Problems ____ Spinal Surgery ____ Herniated Disc
____ Osteoporosis ____ Spina Bifida ____ Other _____

Gastrointestinal

____ Ulcers ____ Nausea ____ Diarrhea/Constipation ____ Bloody Stools
____ Intestinal Ulcers/Colitis ____ Difficult Bowel Movmnt ____ Other _____

Genitourinary

____ Incontinence ____ Difficult Urination ____ Kidney Issues ____ Prostate Pain/Disorders

For Women Only

____ Uterine Fibroids ____ Ovarian Cysts ____ PCOS ____ Severe Menstrual Cramping
____ Number of Pregnancies ____ Other _____

Ears, Nose and Throat

____ Hearing Issues ____ Visual Disturbances ____ Other _____

Neurological

____ Epilepsy/Seizures ____ Dizziness/Fainting Spells ____ Migraines ____ Multiple Sclerosis
____ Psychiatric Disorders ____ Other _____

General Health History

____ Diabetes ____ Cancer ____ Gout ____ General Fatigue
____ Sudden Weight Loss/Gain ____ Shingles ____ Hepatitis ____ HIV+/AIDS
____ Alcohol/Drug Abuse ____ Insomnia ____ Arthritis ____ Other _____

Lifestyle – Please Mark All That Apply To You

____ Alcohol ____ Tobacco ____ Recreational Drugs ____ Caffeine
____ Exercise Regularly ____ Sleep 8+ hrs per night ____ Wear Orthotics

Current Complaint

Patient Name _____ Date _____

Please describe the quality and location of the pain that has brought you to our office today _____

_____

_____

_____

What do you believe has caused this pain?

Fall Lifting/Bending Automobile Accident Accident/Injury at Work Position During Sleep

Other: _____

Please rate your overall pain on a scale from 1 [little to no pain] to 10 [worst pain you have experienced] _____

How have your symptoms affected your daily life?

O – decreased my ability to perform this task **X** – prevented me from performing this task

Daily Activities Affected by Symptoms

____ Sleeping	____ Eating	____ Bathing	____ Dressing
____ Grooming	____ Sitting	____ Standing	____ Bending
____ Lifting/Carrying	____ Running	____ Sexual Relations	____ Driving Car
____ Moving	____ Reading	____ Writing	____ Shopping
____ Traveling	____ Child Care	____ Dining Out	____ Social Events

Activities Within The Home Affected by Symptoms

____ Cooking	____ Ironing	____ House Cleaning	____ Laundry
____ Washing Dishes	____ Vacuuming	____ Dusting	____ Interior Painting

Activities Outside The Home Affected by Symptoms

____ Yard Work	____ Gardening	____ Mowing Lawn	____ Car Washing
____ House Maintenance	____ Farm Activities	____ Pet Care/Exercise	____ Watering Plants

Work Activities Affected by Symptoms

____ Concentration	____ Computer Work	____ Typing	____ Writing
____ Lifting/Carrying	____ Machine Work	____ Using Telephone	____ Standing Long-Term
____ Sitting Long-Term	____ Traveling	____ Level of Patience	

Sports and Hobbies Affected by Symptoms

Please list the sports you are unable to participate in:

_____

_____

Please list the hobbies or activities you are unable to participate in:

_____

_____

Chiropractic Care Goals

____ Achieve and Maintain Full Body Health	____ Increase Range of Motion	____ Improve Overall Body Function
____ Treat Specific Condition or Injury	____ Improve Nutrition	____ Reduce Pain Only

Signature _____ Date _____