Patient General Information Form

Today's Date: ________________ Patient #:________________________

Last Name:______________________ First Name:_______________________ SSN:__________________________

Address:____ DOB:__________________________

City:____________________________ State:______________ Zip:__________ Gender: M or F

Home Phone:_______________ Work/Cell Phone:_______________________ Email:_________________________

Occupation:_________________ Employer:___________________________ Referred by:______________________

Marital Status:_______________ Spouses Name:____________________ Spouses Employer:____________________

Do you have children? ☐ Yes ☐ No How many?___________

INSURANCE INFO

Primary Insurance:____

Claims address:____ Phone #:_____________________

Effective Date:___________________ Policy #:__________________________ Group #:______________________

Relationship to Insured:___________________ Insured Name:_____________ Insured DOB:__________________

Secondary Insurance:____

Claims address:____ Phone #:_____________________

Effective Date:___________________ Policy #:__________________________ Group #:______________________

Relationship to Insured:___________________ Insured Name:_____________ Insured DOB:__________________

Have you been to a Chiropractor before?:______________________________ When:_________________________

Who:______________________________ Reason for care:____

Who is your Medical Doctor?:____ Phone #:_____________________

REASON FOR TODAY'S VISIT

What is your present complaint? ____________________________________ Date started:___________________

Is this condition due to: ☐ Auto accident ☐ Work Injury ☐ Other Accident ☐ Illness ☐ Unknown cause

Please describe your injury/reason for seeking chiropractic care:____

____

Is your condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine? If so, how:________________________

____

Rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (extreme pain)

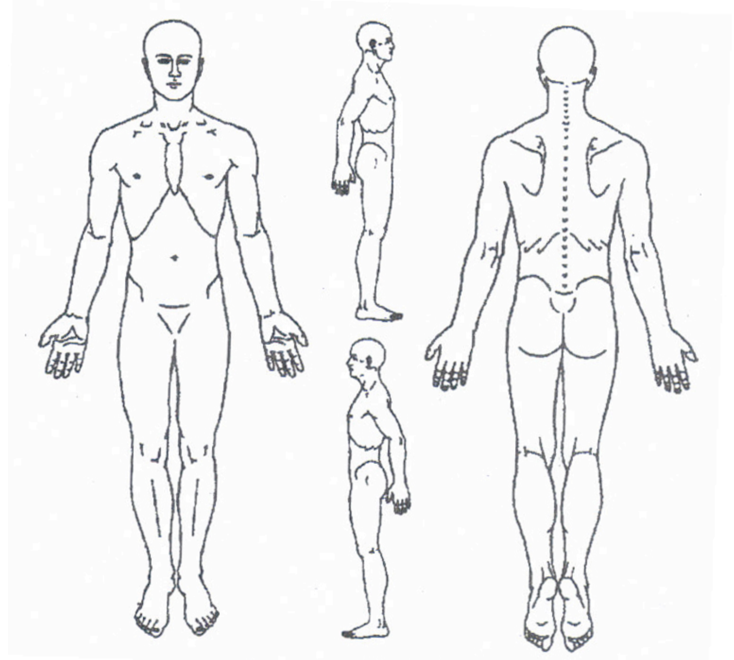
What aggravates your condition(s): ☐ Standing ☐ Twisting ☐ Bending ☐ Sitting ☐ Lying ☐ Walking ☐ Coughing ☐ Lifting

Areas of injury or discomfort:

On the following chart mark area(s) of injury or discomfort.
Mark all the areas with the appropriate symbols and indicate the degree of pain on a scale from 1 (minimal) to 10 (extreme).

NNNN	Numbness
PPPP	Pins & Needles
BBBB	Burning
AAAA	Aching
SSSS	Stabbing

Circle any area of pain not represented by a symbol.



Are your symptoms:
___ Improving
___ About the same
___ Getting worse
___ Intermittent (comes and goes)

Have you had these symptoms before? ☐ No ☐ Yes

HEALTH HISTORY

Major Surgeries: ______________________________
Hospitalizations: ______________________________
Accidents or falls: ______________________________
List all prescription drugs you now take: ______________________________
List all NON-prescription drugs (supplements) you now take: ______________________________
List anything you are allergic to: ______________________________
Do you smoke: ☐ Yes ☐ No If so, how much? ______________ How long? ______________
Do you drink alcohol: ☐ Yes ☐ No If so, how much? ______________ How often? ______________
Do you exercise? ☐ Yes ☐ No If so, how many hours per week? __________
Do you currently wear: ☐ Shoe lifts ☐ Inner Soles ☐ Arch Supports

For Women: Are you Pregnant? ☐ Yes ☐ No If so, how many weeks? ________ Are you nursing? ☐ Yes ☐ No

Please check any of the following that you currently have or have had in the past:

__ Headaches	__ Bronchitis	__ Hiatal Hernia	__ Thyroid Problems
__ Sinus/Allergies	__ Pulmonary Disease	__ Premenstrual Pains	__ Fatigue
__ Asthma	__ Emphysema	__ Joint Pain	__ Depression
__ High Blood Pressure	__ Pneumonia	__ Jaw Pain	__ Chest Pains
__ Low blood pressure	__ Kidney Stones	__ Shoulder Pain	__ Stomach Problems
__ Heart Disease	__ Gastric Ulcers	__ Numbness	__ Arthritis
__ Heart Murmurs	__ Colitis/Spastic Colon	__ Hepatitis A, B, C	__ Sciatica/Buttock Pain
__ Diabetes	__ Acid Reflux	__ HIV/AIDS	__ Dizziness
__ Difficult/Painful Urination	__ ADD/ADHD	__ Fractures	__ Skin Problems

I hereby authorize the doctor(s) and the staff of Northlake Chiropractic to administer any treatments and testing necessary for the purpose of improving my physical condition. The above patient information is true and accurate to the best of my knowledge.

______________________________ ______________________________ ______________

Patient Signature (custodial parent or legal guardian if patient is a minor) | Relationship to patient | Date