Thank you for choosing Chiropractic Pain and Injury Center for your chiropractic needs. Please complete this form in ink. If you have any questions, do not hesitate to ask for assistance, we will be happy to help. We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between patient and provider.

PATIENT INFORMATION

Legal Name: ______________________ Birthdate: __________ Age: ______

What do you like to be called? (Name and/or pronoun): ______________________

Sex (as listed by insurance for billing): __________ Social Security #: ______________

Street Address: ______________________________

City: ______________________ State: ________ Zip Code: ________

E-Mail Address: ______________________

Phone Number: Home __________ Work __________ Cell __________

May we leave a message at: ☐ Home ☐ Work ☐ Cell

Employer: ______________ Occupation: ______________

Emergency Contact: ______________________ Phone: __________

OTHER INFORMATION

Have you seen a chiropractor before? ☐ Yes ☐ No

If so, where? ______________________________

Do you understand what we do? ☐ Yes ☐ No

Is this visit the result of a work related injury or an auto accident? ☐ Yes ☐ No

If "yes" please let our receptionist know.

Primary Care Physician: ______________________ Phone Number: __________

Date Last Seen: __________ May we update them on your condition? ☐ Yes ☐ No

♦♦♦

I have provided correct information on this questionnaire to the best of my knowledge. I have also received a copy of this office's Financial and HIPAA Policies to review. I understand these documents and have had my questions answered. I agree to abide by the terms of these documents for my treatment in this office. I also give permission for CPIC to bill and release any appropriate information needed for payment to my contracted carrier and/or their affiliates.

Patient or Guardian Signature: ______________________ Date: __________

Patient Name:________________ DOB:_________

WELCOME

REASON FOR TODAY'S VISIT

☐ Emergency ☐ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Wellness

Do you have any discomfort? ☐ Yes ☐ No **Rate your pain on the following scale:** 0 1 2 3 4 5 6 7 8 9 10

Did your injury occur during: ☐ Work ☐ Sports/Play ☐ Auto Accident ☐ Routine/Household Activity

When did your condition/accident occur? __________________ **Where did it occur?** ______________________________________

Please explain what happened? ____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes.

Is your condition interfering with your: ☐ Work ☐ Sleep or ☐ Daily routine? **If so, how?** ________________________________

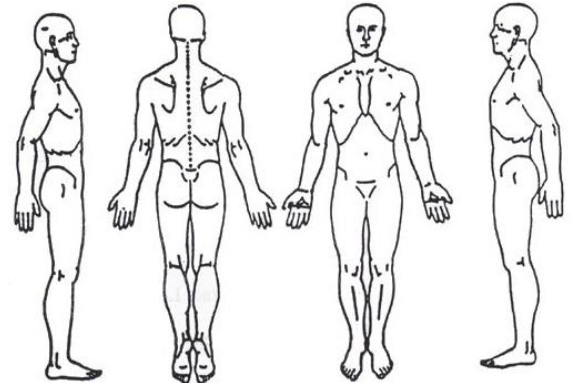
____

Has this or something similar happened in the past? ☐ Yes ☐ No

Explain: ____

____

USING THE ADJACENT CHART, PLEASE CIRCLE ALL AFFECTED AREAS



Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No

If so, Where?

____

Health History

Are you taking any of the following medications?

☐ Nerve pills ☐ Pain Killers (including aspirin) ☐ Muscle Relaxers ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin

Other:____

Do you have or have you had any of the following diseases, medical conditions, or procedures

Y N	Heart Attack/ Stroke	Y N	Heart surg./ Pacemaker	Y N	Heart murmur	Y N	Congenital Heart Defect
Y N	Artificial Valves	Y N	Alcohol/Drug Abuse	Y N	Venereal Disease	Y N	Hepatitis
Y N	Shingles	Y N	Cancer	Y N	Frequent Neck Pain	Y N	Glaucoma
Y N	High/Low Blood Pressure	Y N	Psychiatric Problems	Y N	Rheumatic Fever	Y N	Severe/Frequent Headaches
Y N	Ulcers/Colitis	Y N	Fainting/Seizures/Epilepsy	Y N	Sinus Problems	Y N	Emphysema/Asthma
Y N	Difficulty Breathing	Y N	Chemotherapy	Y N	Lower Back Problems	Y N	Artifical Bones/Joints/Implants
Y N	Mitral Valve Prolapse	Y N	HIV+/AIDS/ARC	Y N	Anemia/Diabetes	Y N	Kidney Problems
Y N	Tuberculosis	Y N	Arthritis				

Please list any surgeries with dates and/or any other serious medical conditions not listed above:___________________________

____

List any serious accidents with dates:____

Please list anything that you may be allergic to:____

Family Health History:____

Do you take vitamins or supplements? ☐ Yes ☐ No **Do you exercise**? ☐ Yes ☐ No **If yes, hours per week**:________________

Do you smoke? ☐ Yes ☐ No **If yes, how much?** ____________________ **For how long?** ___________________________________

Are you wearing: ☐ Shoe lifts ☐ Inner soles ☐ Arch Supports **Are you dieting?** ☐ Yes ☐ No **If yes, for how long?**__________

***FOR WOMEN:* Are you taking Birth Control?** ☐ Yes ☐ No **Are you Nursing?** ☐ Yes ☐ No

Are you Pregnant? ☐ Yes ☐ No **If yes, how many weeks?** _______________________

I understand the above information and guarantee this from was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Or Guardian Signature:____ **Date:**_________________________