CONFIDENTIAL PATIENT INFORMATION

Date________________________________

Social Security No.________________________________

Name____ Home Phone____________________

Address____ Cell Phone____________________

City____________________________ State_____ Zip Code ______________

Age______ Birth Date ______________ Marital Status M S W D How many children?______________

Occupation ______________________________ Employer ______________________________________

Address____ Office Phone ____________________

Insurance Company ___________________________________

Spouse's Name_____________________________ Occupation ______________________________________

Employer ____ Office Phone ____________________

Who referred you to our office? ____

Have you ever received chiropractic care? ☐ No ☐ Yes By whom?____________________________________

Did this injury happen at work? ☐ No ☐ Yes IF YES, PLEASE STOP HERE.

Do you currently have or have you ever suffered recurrently from:

	Yes	*Office use only*		Yes	*Office use only*
Headaches	☐		Asthma	☐	
Dizziness	☐		Sinus Trouble	☐	
Neck Pain/Stiffness	☐		Digestive Disorders	☐	
Sleeping Problems	☐		Diarrhea	☐	
Back Pain/Backaches	☐		Constipation	☐	
Shoulder Pain	☐		Heart Trouble	☐	
Chest Pain	☐		High Blood Pressure	☐	
Fatigue	☐		Low Blood Pressure	☐	
Nervousness	☐		Anemia	☐	
Ears Ringing/Buzzing	☐		Depression	☐	
Loss of Balance	☐		Diabetes	☐	
Fainting	☐		Tuberculosis	☐	
Cold Feet/Hands	☐		Arthritis	☐	
Numbness in Fingers/Toes	☐		Cancer	☐	
Pins/Needles in Arms/Legs	☐		AIDS	☐	

Condition for which you are seeking care? ____

Have you ever had this condition before ☐ No ☐ Yes When? ____________________________________

Names of doctors seen for this condition____

Have you been treated with any health condition by a doctor in the last year? ☐ No ☐ Yes

Describe____

____

OVER PLEASE

1. *Locate your pain in the drawings.*
2. *Shade in the areas of pain.*
3. *Rate the Pain: 1 = Mild*
   2= Moderate
   3= Severe

List all dates/types of surgeries: ____

____

List any accidents (with dates): ____

____

List any previous illnesses, diseases or conditions (with dates): ______________________

____

List any health problems that occur in 2 or more family members: ____________________

____

List any allergies: ____

____

What medications are you currently taking? __________________________________

Do you smoke? ☐ No ☐ Yes How many per day? ______________

How much coffee do you drink? _______/day _____/week

How much soda do you drink? _____/day _____/week

How much alcohol do you drink? _____/day _____/week

Are you on a sugar or salt restricted diet? ☐ No ☐ Yes

PAYMENT IS EXPECTED AT THE TIME OF VISIT, PLEASE

Name of Person responsible for payment: _____________________________________

Are you Insured? ☐ No ☐ Yes Company: _____________________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Giebler Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Giebler Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered to me will be immediately due and payable.

Patient/Guardian Signature: _______________________________________ Date: _______________