Patient Information

Thank you for choosing our practice for your chiropractic needs. Please, if you have any questions or concerns, do not hesitate to ask for our assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ S/S _____-____-_____
First MI Last

Address _____ City_____ State _____ Zip _____

Sex: Female ____ Male ____ E-mail address _____

Birth Date ____-____-_____ Home Phone# _____-_____-_____ Work # ____-____-_____

Do you prefer to receive calls at: Home ___ Work ___ Either ____

Are you: Married ___ Divorced ____ Widowed ____ Single ____ Separated____

Your Employer _____ Occupation _____

Business Address _____ City _____State _____Zip _____

Spouse's or Parent's Name _____ Work Place _____ Phone# _____

Children's Names/Ages _____

Who can we thank for referring you _____

Person to contact in case of an emergency _____ Phone# _____

Insurance Information

(please make sure front office has a copy of your card)

Name of Insurance _____ ID# _____ Group# _____

Complete below information if insured information is different than patient information

Insured's Name _____ Insured's Date of Birth ____-____-_____

Insured's Work Place _____ Insured's Work Phone# ____-____-_____

Insured's Address if different than patient address: _____

Chief Complaint

Reason for visit _____ When did you first notice symptoms _____

Is condition getting progressively worse? _____ Where specifically is problem? _____

Which activities are difficult to perform? ___Sitting ___Standing ___Walking ___ Bending ___Lying Down ___Other _____

Type of pain: ___ Sharp ___ Dull ___ Throbbing ___ Numbness ___ Aching ___ Shooting ___ Burning ___ Tingling ___ Cramps ___ Stiffness ___ Swelling ___ Other

Rate severity of pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition? _____

Name of other doctor(s) who have treated you for your condition? _____

Health History

Check only those conditions which are applicable:

☐ AIDS/HIV	☐ Cataracts	☐ Hepatitis	☐ Osteoporosis
☐ Alcoholism	☐ Chemical Dependency	☐ Hernia	☐ Pacemaker
☐ Allergy Shots	☐ Chicken Pox	☐ Herniated Disc	☐ Pinched Nerve
☐ Anemia	☐ Depression	☐ Herpes	☐ Pneumonia
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Polio
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	☐ Prostate Problems
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	☐ Prosthesis
☐ Asthma	☐ Fractures	☐ Measles	☐ Psychiatric Care
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraine Headaches	☐ Rheumatoid Arthritis
☐ Chest Lump	☐ Goiter	☐ Miscarriage	☐ Rheumatic Fever
☐ Bronchitis	☐ Gonorrhea	☐ Mononucleosis	☐ Scarlet Fever
☐ Bulimia	☐ Gout	☐ Multiple Sclerosis	☐ Stroke
☐ Cancer	☐ Heart Disease	☐ Mumps	☐ Whooping Cough
☐ Suicide Attempt	☐ Tuberculosis	☐ Ulcers	☐ Other _____
☐ Thyroid problems	☐ Tumors, Growths	☐ Vaginal Infections	☐ _____
☐ Tonsillitis	☐ Typhoid Fever	☐ Venereal Disease	

Dates of last exam _____

(Women) Are you pregnant? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

List any types of surgeries which you have had and the dates which they occurred:

_____

_____

Please list all medications you are currently taking: _____

Allergies: _____

Daily Habits

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What do your daily work habits include? (Ex. sitting, light labor, heavy labor, computer work)

_____

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take? _____

Do you smoke? ☐ Yes ☐ No How much per day? _____

How much alcohol do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Do you consume diet products (ex. diet soda) that contain Nutrasweet? ☐ Yes ☐ No

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor insurance benefits otherwise payable to me. **I understand my chiropractic insurance carrier may pay less than the actual bill for services, I agree to be responsible for payment of all services rendered on my behalf or my dependent.**

X _____

Signature of patient(or parent of minor) Date

STUCKEY FAMILY CHIROPRACTIC HAS MY PERMISSION TO SEND ME APPOINTMENT REMINDERS/MISSED APPOINTMENT CORRESPONDENCE.

_____ YES _____ NO

STUCKEY FAMILY CHIROPRACTIC HAS MY PERMISSION TO LEAVE A PHONE MESSAGE OR VERBAL MESSAGE WITH WHEVER ANSWERW THE PHONE REGARDING APPOINTMENT INFORMATION OR CONCERNS REGARDING MY CARE.

_____ YES _____ NO

I HAVE HAD THE OPPORTUNITY TO REVIEW THE STUCKEY FAMILY CHIROPRACTIC PRIVACY (HIPPA) POLICY.

_____ YES _____ NO

SIGNATURE _____

DATE _____