C.J. MEYER CHIROPRACTIC

# W E L C O M E

## PATIENT INFORMATION

Name _____ SSN_____ Today's Date_____

Address_____ Sex ____ Marital Status _____ Spouse's Name_____

City/St/Zip _____ Date of Birth_____ Age _____

Home Phone_____ Work Phone_____ Occupation_____

Cell Phone _____ Email Address _____

In Case of Emergency, Contact: _____ Phone _____ Relationship_____

Whom may we thank for referring you? _____

## PATIENT CONDITION

Reason for Visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes ____No ____Unknown____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

Type of pain: Sharp ___ Dull ___ Throbbing ___ Numbness ___ Aching ___ Shooting ___ Burning ___ Tingling___
Cramps ___Stiffness ___Swelling ___Other: Describe _____

How often do you have your symptom? _____

Where is it located (be specific as possible): _____

Does it interfere with your Work ___ Sleep ___ Daily Routine ___ Recreation ___ Other: Describe _____

Activities or movements that are painful to perform: Sitting ___Standing ___Walking ___Bending ___Lying Down ___

What health concerns are you being treated by a health professional for? _____

## HEALTH HISTORY

What treatments have you already received for your condition? Medication ___Surgery ___Physical Therapy ___
Chiropractic Services ___None ___Other: Describe _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Dental X-Ray _____ Chest X-Ray _____ Urine Test _____
Spinal Exam _____ MRI, CT-Scan, Bone Scan _____

Injuries/Surgeries you have had Description Date

Falls _____

Head Injuries _____

Surgeries _____

Are you pregnant? Yes ____ No ____ Due Date: _____ Last Menstrual Period: _____

| **EXERCISE** | **WORK ACTIVITY** | **HABITS** | | | |
|---|---|---|---|---|---|
| | | | Little | Moderate | Lots |
| Amount _____ | Sitting _____ | Smoking | ____ | ____ | ____ |
| Type _____ | Type of Work _____ | Alcohol | ____ | ____ | ____ |
| Enjoy it? _____ | Light ___ Heavy ____ | Stress | ____ | ____ | ____ |

| **MEDICATIONS** | **ALLERGIES** | **VITAMINS/MINERALS/HERBS** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## ACCIDENT INFORMATION

Is this condition due to an accident? Yes ___ No ___ Date if applicable: _____
Type of accident: Automobile ___ Work ___ Home ___ Other: Describe: _____
To whom have you made a report of your accident? Auto insurance ___ Employer ___ Worker's Comp ___ Other_____
Attorney's Name (if applicable): _____

## INSURANCE INFORMATION

Who is responsible for this account? _____ Relationship _____

Insurance Company _____ Group Number _____

Place of Employment _____ ID Number _____

Payments for chiropractic services are expected at time of care. I, the undersigned, understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____