

Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home: _____ Work: _____ Cell: _____

e-mail: _____ SS #: _____ Sex: M F

Married Single Divorced Separated Other _____

Name of Spouse or Nearest Relative: _____

Phone: Work _____ Cell: _____

Your Employer: _____

Occupation: _____

Referred to this office by: Web Site Yellow Pages Advertisement

Friend/Family Member Name: _____

Payment for Services will be by: Cash Check Credit Card Health Insurance Automobile Insurance

Are you covered by more than one insurance company? Yes No Name _____

Insurance Information

Name of Company: _____

Name of Insured: _____

Insureds DOB: _____ SS#: _____

I certify that I or my dependents have insurance coverage with the above listed company and assign directly to Radcliff Family Chiropractic all insurance benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature of Patient: _____

Print Name: _____

Date: _____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STD

Have you been treated by a physician for any health condition in the last year? Yes No

Describe Condition _____ Date of Last Physical Exam _____

Describe The Treatment: _____

SURGICAL HISTORY: NONE

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

Have you ever had a metal implant? Yes No Ever been gunshot? Yes No

ACCIDENT HISTORY: Job Auto Other 1. _____ Date: _____

Job Auto Other 2. _____ Date: _____

Job Auto Other 3. _____ Date: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

CHECK HERE IF YOU HAVE NO SYMPTOMS AND ARE HERE FOR WELLNESS CARE

Area/Body Part	Intensity					Frequency			
1) _____	Minimal	Slight	Moderate	Marked	Severe	Intermittent	Occasional	Frequent	Constant
2) _____	Minimal	Slight	Moderate	Marked	Severe	Intermittent	Occasional	Frequent	Constant
3) _____	Minimal	Slight	Moderate	Marked	Severe	Intermittent	Occasional	Frequent	Constant
4) _____	Minimal	Slight	Moderate	Marked	Severe	Intermittent	Occasional	Frequent	Constant
5) _____	Minimal	Slight	Moderate	Marked	Severe	Intermittent	Occasional	Frequent	Constant

If you are experiencing pain, is it...

- Dull
- Sharp
- Stabbing
- Achy
- Tingling/Numb
- _____

Since the problem started, it is...

- About the Same
- Getting Better
- Getting Worse

Symptoms are worse in: MORNING AFTERNOON NIGHT **Worse with:** Sitting Standing Laying Movement

What makes your symptoms better: Rest Ice Heat Medication _____ Nothing

WHEN AND HOW DID YOUR SYMPTOMS BEGIN: _____

- Gradual Onset
- Job Accident
- Car Accident
- Illness
- Unknown
- Other: _____

Have you had this problem before? Yes No When: _____ How was it treated? _____

Name of doctor previously seen for this condition: _____

If you were to guess, What do you think is causing your complaints? _____

Are you allergic to any medications or supplements? Yes No What kind? _____

Please list all medications currently taking: _____

Are you Pregnant? Yes No Date of last menstrual period: _____

PLEASE CHECK THE FOLLOWING THAT AGGRAVATES YOUR CONDITION:

- Bending
- Reaching
- Coughing
- Lifting
- Sneezing
- Walking
- Turning Your Head
- Straining at Stool

PLEASE LIST ANY ACTIVITIES YOU AVOID OR CAN'T DO DUE TO YOU CONDITION: _____

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

- blurred vision
- buzzing in ears
- cold feet
- cold hands
- concentration loss/confusion
- constipation
- fainting
- diarrhea
- dizziness
- cold sweats
- depression/weeping spells
- face flushed
- fatigue
- fever
- headaches
- insomnia
- head feels heavy
- light bothers eyes
- loss of balance
- loss of smell
- loss of taste
- stiff neck
- low resistance to colds
- muscle jerking
- numb fingers
- numbness in toes
- tingling legs
- tingling arms
- shortness of breath
- ringing in ears
- acid reflux
- upset stomach
- PMS
- ear infections
- decreased athletic performance
- baby with colic

The information I have provided is accurate to the best of my recollection and is intended to provide Radcliff Family Chiropractic with necessary information in order to diagnose my condition(s) and to determine the appropriate treatment. By providing this information it is my intent to be examined, diagnosed and treated by Radcliff Family Chiropractic and for no other purpose.

Patients Signature: _____ Date: _____

Print Name: _____