

Buckeye Chiropractic Clinic, Inc.

Confidential Patient Information

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

PATIENT INFORMATION

Today's Date: _____

Name: _____
(last name) (first name) (m.i.)

Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Social Security #: _____ Age: _____ Male Female

Marital Status:

- Married Separated
 Single Other _____
 Divorced

Name of Spouse/Nearest Relative: _____ Phone: _____

Your Occupation _____ Your Employer: _____

Referred to this Office by:

- Friend/Family Member Name? _____
 Yellow Pages
 Mail
 Clinic Location
 Other _____

Payment for Services will be:

- Cash Health Insurance
 Check Automobile Insurance
 Credit Card Worker's Compensation

Name of Insurance Co.: _____

Insured's Employer: _____

Insured's Social Security #: _____

Employer's Phone #: _____

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

If Yes, Name of other insurance company _____

MEDICAL/FAMILY HISTORY

(S = Self • M = Mother • F = Father)

(Please indicate which PAST conditions have been experienced PRIOR to present complaint by marking appropriate boxes)

<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">S</th> <th style="text-align: left;">M</th> <th style="text-align: left;">F</th> <th></th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>AIDS</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>anemia</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>arthritis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>asthma</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>back pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>bladder trouble</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>bone fracture</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>cancer</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>chest pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>concussion</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>convulsions</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>diabetes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>indigestion</td></tr> </tbody> </table>	S	M	F		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<table style="width: 100%; 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Are you pregnant or have reason to believe you maybe pregnant? Yes No

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

If yes, describe Condition _____

Date of Last Physical Exam _____

SURGICAL HISTORY:

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: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please rate your symptoms (1-10, with 1 being least serious)

<u>Description</u>	<u>Rating</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

SYMPTOMS ARE WORSE IN MORNING AFTERNOON NIGHT

WHEN AND HOW OCCURRED?

SYMPTOMS DEVELOPED FROM:

- JOB RELATED INJURY ILLNESS ACCIDENT
 AUTO ACCIDENT UNKNOWN CAUSE
 OTHER GRADUAL ONSET

DATE OCCURRED: _____

SYMPTOMS HAVE LASTED: ____ HOUR(S) ____ DAY(S) ____ WEEK(S) ____ MONTH(S) ____ YEAR(S)

SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANTHAVE YOU EVER HAD THIS BEFORE: NO YES WHEN? _____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

LIST ANY MEDICINE ALLERGIES _____

LIST ANY MEDICATIONS YOU ARE TAKING

ARE YOU PREGNANT NO YES DATE OF LAST MENSTRUAL PERIOD _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

- | | | |
|-------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> BENDING | <input type="checkbox"/> REACHING | <input type="checkbox"/> STRAINING AT STOOL |
| <input type="checkbox"/> COUGHING | <input type="checkbox"/> SITTING | <input type="checkbox"/> TURNING HEAD |
| <input type="checkbox"/> LIFTING | <input type="checkbox"/> SNEEZING | <input type="checkbox"/> WALKING |
| <input type="checkbox"/> LYING DOWN | <input type="checkbox"/> STANDING | |

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

- | | | |
|-----------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> BENDING | <input type="checkbox"/> SITTING | <input type="checkbox"/> LIFTING |
| <input type="checkbox"/> STANDING | <input type="checkbox"/> LYING DOWN | <input type="checkbox"/> TURNING HEAD |
| <input type="checkbox"/> REACHING | <input type="checkbox"/> WALKING | |

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

- | | | |
|---|--|---|
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> fatigue | <input type="checkbox"/> numbness in toes |
| <input type="checkbox"/> buzzing in ears | <input type="checkbox"/> fever | <input type="checkbox"/> pins and needles in arms |
| <input type="checkbox"/> cold feet | <input type="checkbox"/> head seems too heavy | <input type="checkbox"/> pins and needles in legs |
| <input type="checkbox"/> cold hands | <input type="checkbox"/> headaches | <input type="checkbox"/> ringing in ears |
| <input type="checkbox"/> cold sweats | <input type="checkbox"/> insomnia | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> concentration loss/confusion | <input type="checkbox"/> light bothers eyes | <input type="checkbox"/> stiff neck |
| <input type="checkbox"/> constipation | <input type="checkbox"/> loss of balance | <input type="checkbox"/> stomach upset |
| <input type="checkbox"/> depression/weeping spells | <input type="checkbox"/> loss of smell | |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> loss of taste | |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> low resistance to colds | |
| <input type="checkbox"/> face flushed | <input type="checkbox"/> muscle jerking | |
| <input type="checkbox"/> fainting | <input type="checkbox"/> numbness in fingers | |

Disclaimer

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all moneys will be credited to my account upon receipt. I, also authorize the release of any health information necessary to process this claim. However, I clearly understand and agree that all services rendered 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, the fees for professional services rendered me will be immediately due and payable. In the event of default I agree to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patient's Signature: _____ **Date:** _____