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)

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

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)

Description Rating

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 CONSTANT

HAVE 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 MEDICTIONS YOU ARE TAKING

ARE YOU PREGNANT ☐ NO ☐ YES DATE OF LAST MENSTRUAL PERIOD _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

- ☐ BENDING
- ☐ COUGHING
- ☐ LIFTING
- ☐ LYING DOWN
- ☐ REACHING
- ☐ SITTING
- ☐ SNEEZING
- ☐ STANDING
- ☐ STRAINING AT STOOL
- ☐ TURNING HEAD
- ☐ WALKING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

- ☐ BENDING
- ☐ STANDING
- ☐ REACHING
- ☐ SITTING
- ☐ LYING DOWN
- ☐ WALKING
- ☐ LIFTING
- ☐ TURNING HEAD

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

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

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: _____