Personal Information

Today's date_____

Last name_____ First name_____ Middle initial_____

Date of birth_____ Gender____ Social Security number_____

Weight_____ Height_____ Marital Status____ Referred to Dr. Beck by _____

Are you an active smoker _____ Frequency_____ Are you a previous smoker_____

Address_____ City_____ State_____ Zip_____

Home phone_____ Work phone_____ Cell phone_____

Which phone do you prefer to be contacted on _____

Email address_____ Reminder email about next appt?____

Employment Information

Employer name _____ Employer phone _____

Address _____ City_____ State____ Zip_____

Job title/description _____

Emergency Contact

Contact name _____ Relationship to patient_____

Address _____ City_____ State___ Zip_____

Home Phone _____ Cell Phone_____

Insurance Information

Primary Insurance:

Insurance name _____ Subscriber ID_____ Group #_____

Address _____ Relationship to primary insured_____

Secondary Insurance:

Insurance name_____ Subscriber ID_____ Group #_____

Address_____ Relationship to primary insured _____

Chiropractic Case History

Have you ever received Chiropractic Care? Yes No If yes, when?_____

1. Primary reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

2. Chief Complaint: _____

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

_____

_____

4. Past Health History:

A. Previous illnesses you've had in your life: _____

_____

B. Previous injury or trauma:_____

_____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Medication	Reason for taking

E. Surgeries:

Date	Type of Surgery

**** Do you have a pacemaker?**_____

Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome

What was the date of the beginning of your last menstrual period? _____

5. Family Health History:

Associated health problems of relatives: _____

_____

Deaths in immediate family:

Cause of parents or siblings death	Age at death

6. Social and Occupational History:

A. Level of Education:

O high school O some college O college graduate O post graduate studies

B. Job description: _____

C. Work schedule: _____

D. Recreational activities: _____

E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient (Guardian) Signature _____ Date _____

Doctors Signature _____ Date _____