Welcome to Crystal Chiropractic

Patient Information

Today's Date: _____ Referred By:_____

Patient Name: _____

What do you prefer to be called? _____

Street Address: _____

City: _____State: _____Zip: _____

Sex: Male Female **SSN: _____ DOB: _____**

Marital Status: Minor Single Married Divorced Separated Widowed

Employer: _____

List the numbers in which Crystal Chiropractic can call and/or leave a message regarding appointments, Insurance coverage, or to return your call.

(Home)_____ (Cell)_____ (Work)_____

On occasion (4-6 times a year), we send Health Tips, Newsletters or Special Promotions to our current patients. We don't share your confidential information with anyone. Would you like to receive this information by email? Yes or No
Email:(print)_____

Insurance Information: *If you are the insured, skip the next two lines.*
Insured's Name: _____ DOB: _____
SSN: _____ Relation:_____Employer: _____

Who should we contact in the event of an emergency? _____
Relation: _____ Phone # _____

Who is your Medical Doctor? _____

Please list any person who has permission to present your child for treatment:
N/A_____

I acknowledge that I have received a copy of the Health Insurance Privacy Act, the consent for use or disclosure of health information, the appointment reminders and health care information, and a marketing authorization. This Notice is effective as of March 15,2011. This notice will expire six years after the date upon which the record was created.

Print Name: _____ Sign Name: _____
Date: _____

Health History

What medications do you take, reasons, and date started? Example: nerve pills, pain killers, aspirin, muscle relaxers, stimulants, blood thinners, tranquilizers, cholesterol, insulin…

_____

_____

D**o you have the following conditions: (circle all that apply)**

Heart Attack/Stroke	Heart Surgery/Pacemaker	Heart Murmur	Mitral Valve Prolapse
Alcohol/Drug Abuse	Hepatitis/HIV+/Aids	Frequent Neck Pain	Cancer/Chemotherapy
Arthritis	Severe/Frequent Headaches	Psychiatric Problems	Kidney problems
High/Low Blood Pressure	Ulcers/Colitis	Sinus problems	Fainting/Seizures/Epilepsy
Asthma/Breathing problems	Diabetes/Tuberculosis	Artificial Joints	Lower Back problems

Other medical conditions?_____
Allergies: food, medicine, seasonal, other:_____
Serious Accidents/surgeries: _____
Family health history?_____
What supplements do you take? None _____

_____

Are you interested in an evaluation to determine if you have deficiencies that require Supplementation? Yes No
Do you Exercise? Yes No **Do you Smoke?** Yes No
Do you have Orthotics or arch supports? Yes No **Do you need new Orthotics?** Yes No
Is your mattress comfortable? Yes No **Do you sleep on a cervical pillow?** Yes No
Are you taking Birth Control? Yes No **Are you pregnant?** Yes No weeks: _____

Health Concerns (in order)…

1st Complaint: _____ **When did it start?**_____
2nd Complaint:_____ **When did it start?**_____
3rd Complaint:_____**When did it start?**_____
In regards to your primary complaint, **how did it occur?** _____

_____

Is this condition getting worse? Yes No
Is the pain: Constant Comes and goes **On scale of 1-10 rate your pain**: _____ (10 = severe)
Is this condition interfering with your (please circle): work daily routine
Does it wake you up? Yes No **Is it there when you wake up?** Yes No
Does it get worse through the day? Yes No
What makes the problem worse? Sitting standing lying down bending lifting twisting
What makes it better?

_____

Is the pain: sharp radiating dull ache shooting tingling spasm tight
Have you had this condition in the past? Yes No
Have you been treated by your Medical Physician for this condition? Yes No
If so, Who? _____
What things have you done for your pain that is not working?_____

_____

Have you ever seen a Chiropractor before? Yes No **Whom?** _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any change to the information that I have provided.
Signature:_____Date:____/_____/_____

Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

Stabbing/Cutting - |||||
Burning – XXX
Numbness - ======
Tingling - : : : :
Cramping - ^^^
Dull - #####