

Patient Record

Case No.

Date

Patient's Name:		Social Security No:	
Home Address:			
City:	State:	Zip:	Phone:
Occupation:		Employer	How Long?
Business Address:			
City:	State:	Zip:	Phone:
Age:	Date of Birth:	Birthplace:	Sex: S <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> SEP <input type="checkbox"/> D <input type="checkbox"/>
Spouse:		Occupation:	
Referred by:		Email:	

AUTOHRIZATION AND RELEASE:

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the Dr. to release all information necessary to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.

Authorizing Care _____ Patient's Signature _____ Date _____
or Guardian's Signature _____ Date _____

Major Complaint:

Activity Restriction:

Time Missed from Work:

Describe pain: sharp ___ dull ___ numbness ___ tingling ___ aching ___ burning ___ stabbing ___

What makes problem worse: standing ___ sitting ___ lying ___ bending ___

When did you first notice this:

Has this happened before?

Is it worse/better in AM/PM?

Any radiation of pain into an extremity (where)?

Is there any position that relieves the pain? (If so, what position)

Frequency (Pain):

What has been done for this condition?

Did it help?

Anyone recommend surgery?

Medication taken for this condition:

On any regular medication?

Have you consulted a doctor for this condition before?

