_____
Patient Number
(Office Use Only)

PLEASE NOTE:

This file must be saved to your desktop before and after completing!

PATIENT INFORMATION

Date _____ First Name _____ Middle Name _____ Last Name _____

SSN _____ Sex _____ Birth Date _____ Height _____ Weight _____

Marital Status _____ Spouse Name _____ Number of Children _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Emergency Contact _____

Emergency Relation _____ Emergency Phone _____

EMPLOYER INFORMATION

Employed? Yes No

Employer Name: _____

Occupation: _____

Referral Source _____

INSURANCE INFORMATION

Primary Insurance Information

Insurance Company Name _____ Plan Name _____

Phone # _____ Primary ID/Policy _____ Primary Group # _____

Policy Holder's Name _____ Policy Holder's DOB _____

If you are NOT the Policy Holder, what is your relation to the Policy Holder? _____

For verification puposes, what is the Policy Holder's Social Security Number? _____

Secondary Insurance Information

Insurance Company Name _____ Plan Name _____

Phone # _____ Secondary ID/Policy _____ Secondary Group # _____

Policy Holder's Name _____ Policy Holder's DOB _____

If you are NOT the Policy Holder, what is your relation to the Policy Holder? _____

For verification puposes, what is the Policy Holder's Social Security Number? _____

We Take Your Health Seriously

That being said, please take the time to fill this paperwork out **IN ITS ENTIRETY.** This will help the doctor more accurately diagnosis your issues which will lead to better outcomes for you. Thanks! (If a question does not apply, please mark N/A)

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REASON FOR VISIT

Describe in your own words why you wanted to come for an appointment today:

PERSONAL HEALTH INFORMATION

Complaints/Concerns

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptom has been present.

Problem	Onset	Frequency	Severity
E.g. Headaches	*June 2007*	*4 times per week*	*Mild / Moderate / Severe*
1.			
2.			
3.			
4.			
5.			
6.			
7.			

When was the last time you felt well? _____

Did something trigger your health changes?

Sleep

Average number of hours you sleep? _____ Do you have trouble falling asleep? ○ Yes ○ No

Do you feel rested upon awakening? ○ Yes ○ No Do you have problems with insomnia? ○ Yes ○ No

Do you snore? ○ Yes ○ No Do you use sleeping aids? ○ Yes ○ No Explain: _____

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Injuries

Describe your injury and pain:

Type of injury

How did it occur? ☐ Work ☐ Automobile ☐ Fall ☐ Other _____

Injury Date _____ Have you missed work related to this injury? ○ Yes ○ No

Unable to work from (dates) _____ to _____

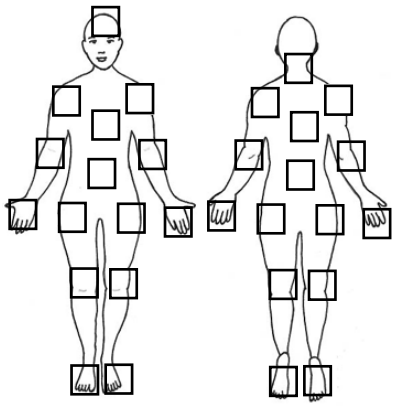
Received other treatment for this? ○ Yes ○ No Where or by whom? _____

X-rays taken? ○ Yes ○ No

Please check the character of your current pain (you may check more than one):

Sharp ☐ Stabbing ☐ Dull ☐ Aching ☐ Soreness ☐ Stiffness ☐ Weakness ☐

Numbness ☐ Shooting ☐ Burning ☐ Tingling ☐ Throbbing ☐



Pain level on scale of 1 - 10 (10 is excruciating pain) At its best?_____ At its worst? _____

Now? _____

How often are your symptoms present?

Constant ☐ Frequent ☐ Occasional ☐ Intermittent ☐

Since your problem began, is the pain? Increasing ☐ Decreasing ☐ No Change ☐

What activities make symptoms BETTER? Sitting ☐ Standing ☐ Laying Down ☐

Movement/Exercise ☐ Sleep/Rest ☐ Other(describe) _____

What activities make symptoms WORSE? Sitting ☐ Standing ☐ Coughing/Sneezing ☐

Movement/Exercise ☐ Sleep/Rest ☐ Other(describe) _____

Do you currently receive chiropractic care? ○ Yes ○ No

What clinic or chiropractor provides that care? _____

Did you receive chiropractic care in the past? ☐ Yes ☐ No If yes, where? _____

Tobacco/Alcohol

Currently using tobacco? ○ Yes ○ No How many years? _____ Packs per day _____

If yes, what type? ☐ Cigarette ☐ Smokeless ☐ Cigar ☐ Pipe ☐ Patch/Gum

Previous smoking? How many years? _____ Packs per day _____ Are you exposed to 2nd hand smoke? ○ Yes ○ No

If yes, explain: _____

How many drinks currently per week? (1 drink=5 oz. wine, 12 oz. beer, and/or 1.5 oz. spirits)

☐ None ☐ 1 to 3 ☐ 4 to 6 ☐ 7 to 10 ☐ More than 10

Previous alcohol intake? ○ Yes ○ No If yes, was it: ○ Mild ○ Moderate ○ High

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Allergies

I am allergic to the following medications:

I am allergic to the following foods or supplements:

Please list your symptoms/reactions to the above medications and/or foods:

Medications and Supplements

Medications: Please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs.

Medication Name	Dosage

Supplements: List all vitamins, minerals, and other nutritional supplements that you are currently taking.

Supplement Name	Dosage

Health History

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Have you ever had any of the following:

Illnesses	Yes	No
Chicken Pox	☐	☐
Measles	☐	☐
Mumps	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Chronic Fatigue Syndrome	☐	☐
Crohn's Disease or Ulcerative Colitis	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy, convulsions	☐	☐
Gallstones	☐	☐
Gout	☐	☐
Heart attack/Angina	☐	☐
Heart failure	☐	☐
Hepatitis	☐	☐
High Blood Pressure	☐	☐
Irritable bowel	☐	☐
Kidney stones	☐	☐
Mononucleosis	☐	☐
Pneumonia	☐	☐
Rheumatic fever	☐	☐
Sinusitis	☐	☐
Sleep Apnea	☐	☐
Stroke	☐	☐
Thyroid disease	☐	☐
Other (describe)		

Injuries	Yes	No
Head Injury		
Neck Injury		
Back Injury		
Fracture		
Other (describe)		

Diagnostic Studies	Yes	No	Date / Location
Chest X-ray	☐	☐	
Mammogram	☐	☐	
EKG	☐	☐	
Colonoscopy	☐	☐	
Upper GI Series	☐	☐	
Barium Enema	☐	☐	
CAT scan of abdomen	☐	☐	
CAT scan of brain	☐	☐	
CAT scan of spine	☐	☐	
Liver scan	☐	☐	
Bone scan	☐	☐	
Neck X-rays	☐	☐	
Back X-rays	☐	☐	
MRI	☐	☐	
Bone Density Test	☐	☐	
Blood Tests	☐	☐	
Other (describe)			

Operations	Yes	No
Tonsillectomy	☐	☐
Tubes in Ears	☐	☐
Appendectomy	☐	☐
Gall Bladder	☐	☐
Hernia	☐	☐
Hysterectomy	☐	☐
Dental Surgery	☐	☐
Other (describe)		

Hospitalizations

When	For What Reason	Location

Women Specific

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Check the box if yes and provide number.

☐ Pregnancies _____ ☐ Miscarriage _____ ☐ Living Children _____ ☐ Abortion _____ ☐ Cesarean _____

☐ Vaginal Delivery _____ ☐ Postpartum Depression _____ ☐ Toxemia _____ ☐ Baby Over 8 Pounds _____

☐ Gestational Diabetes _____ Are you currently pregnant? Yes ☐ No ☐

Menstrual History

Age At 1st Period _____ Menses Frequency _____ Length _____

Painful? ○ Yes ○ No Clotting? ○ Yes ○ No Have you ever missed your period? ○ Yes ○ No

For how long? _____ Are you menopausal? ○ Yes ○ No Age At Menopause _____

Last Menstrual Period _____

Do you take any hormone contraception? ☐ Birth Control Pill ☐ Patch ☐ Nuva Ring

Acknowledgments

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial.

I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in the practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure and disease or entity.

Initials:_____

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials:_____

I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY) _____

Initials:_____

I grant permission to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials:_____

I acknowledge that any insurance I may have is an agreement between the center and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials:_____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.

Initials:_____

Please email this completed form to **info@drosmon.com**

By typing or signing your name below on the signature line, you are agreeing to all of the paragraph above.

Signature _____ Date _____

Thank you!