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: ________

## 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? ________

## REFERRAL INFORMATION

I was referred by ____________________________________________________________________________

____________
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How did you hear about the clinic?

Advertisement  Newspaper  Community Event  Provider Talk  Family/Friend  Other ____________________

## 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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## Condition

Describe your condition: ____________________

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

Type of injury, if applicable ____________________

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

Condition Onset Date ____________ Have you missed work related to this condition? ◯ Yes ◯ No

Unable to work from (dates) ____________ to ____________

Received other treatment for this? ◯ Yes ◯ No When and by whom? ____________________

X-rays taken? ◯ Yes ◯ No Do you currently receive chiropractic care? ◯ Yes ◯ No

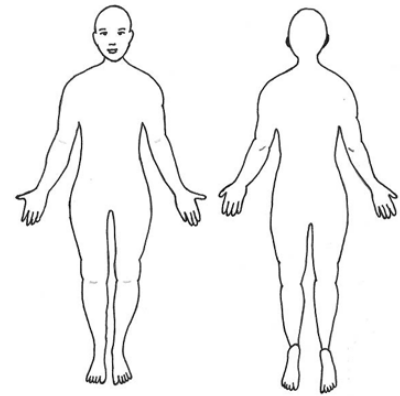
What clinic or chiropractor provides that care? ____________________

Did you receive chiropractic care in the past? Yes No If yes, when and where? ____________________

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

Sharp Stabbing Dull Aching Soreness Stiffness Weakness

Throbbing Numbness Shooting Burning Tingling



Please rate the degree of you pain between 0-10, 0 being no pain and 10 being unbearable: ______

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) ____________________

## 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 |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

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**Health History**

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 Performed |
|---|---|---|---|
| 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 |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**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!