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SPINAL CHECK FOUNDATION LLC
CHIROPRACTIC
HEALTHCARE

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Date _____ **PATIENT INFORMATION** Case#_____

Doctor_____

PLEASE FILL IN THE APPROPRIATE SPACES. (All information you give is confidential)

Patient Name (Last)_____ (First)_____

Street Address_____ Apt #_____

City _____ State_____ ZIP_____ Email_____

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

Sex ☐ M ☐ F Date of Birth ____/____/____ Social Security #____-____-____

Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced Spouses Name _____ # of children_____

Employed ☐ Full Time ☐ Part Time ☐ Retired ☐Not Employed ☐ Student

Occupation _____Patient's Employer's Name _____

Address _____

City _____ State _____ ZIP _____ Phone _____

How did you hear about our office? _____ Referred by _____

Emergency Contact: _____ Phone: _____ Relationship:_____

INSURANCE INFORMATION (commercial Insurance and Medicare only)

Primary Insurance Company _____ Type ☐ Group ☐ Private

ID/Policy # _____ Group Name _____Group Number_____

Insured's Name _____ Insured's Date of Birth ____/____/____

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other Insured's Employer_____

Secondary Insurance Company _____Type ☐ Group ☐ Private

ID/Policy # _____ Group Name _____Group Number_____

Insured's Name _____ Insured's Date of Birth ____/____/____

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other Insured's Employer_____

AUTOMOBILE ACCIDENT / WORKER'S COMPENSATION ONLY

Insurance Company _____Policy #_____ Claim # _____

Adjuster's Name_____Address _____MedPay? ☐ Yes ☐ No

City _____ State _____ ZIP _____ Phone _____

Attorney's Name _____Contact Name _____Phone_____

Address _____

RELEASE AND ASSIGMENT: I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Patient Signature _____Date _____

Date _____ **PATIENT HISTORY** Case#_____

Doctor_____

PLEASE FILL IN THE APPROPRIATE SPACES. (All information you give is confidential)

MAJOR COMPLAINT: _____

How long have you had this condition? _____

Date of Onset?_____

Have you lost workdays? ☐ Yes ☐ No If Yes, how many?_____

Have you had the same condition before ? ☐ Yes ☐ No If yes, when?_____

Was the injury accident related ? ☐ Auto Accident ☐ Work Accident If yes, when?_____

Previous Chiropractic Care? ☐ Yes ☐ No Chiropractor's Name_____

What was the reason for your initial visit?_____

What spinal maintenance programs were you given to follow to maximize the future stability of your spine?_____

Did you follow it? _____ If not, why? _____

_____

What surgeries have you had _____

List drugs you now take (prescription and non-prescription)_____

_____

_____

Name other doctors you have seen for this condition: _____

What are your health goals?_____

How do you expect to achieve these goals? _____

_____

Please mark if you have had any of these symptoms in the last 12 months:

☐ Fractured bones
☐ Auto accidents
_____0-1 years ago
_____2-5 years ago
_____6 years or more
☐ Other accidents, falls
☐ Arthritis
☐ Diabetes
☐ Convulsions, epilepsy
☐ Skin problems
☐ Cancer
☐ Frequent colds, flu
☐ Depressed
☐ Irritable
☐ Anemia
☐ Allergy, Sinus
☐ Under stress
☐ Eating disorders
☐ Trouble sleeping
☐ Trouble concentrating
☐ Learning disability
☐ Mood Changes

☐ Neck pain or Stiffness
☐ Numbness, tingling, pain in arms, hands, fingers R L
☐ Jaw pain or click (TMJ) R L
☐ Difficulty in excessive
Standing, sitting, riding
Bending, lifting, twisting
☐ Shoulder pain
☐ Dizziness
☐ Ringing in ears R L
☐ Hearing Loss
☐ Blurred or double vision
☐ Upper back pain, stiffness
☐ Mid back pain, stiffness
☐ Lower back pain, stiffness
☐ Pain with cough, sneeze
☐ Hip pain R L
☐ Headaches
☐ ADD/ADHD

☐ Numbness, tingling, pain in buttocks, legs, feet, toes R L
☐ Foot Trouble R L
☐ Heart Problems
☐ Stroke
☐ High/Low Blood Pressure
☐ Chest Pain, Asthma
☐ Liver trouble
☐ Gall bladder problems
☐ Digestive problems
☐ Ulcers
☐ Hemorrhoids
☐ Prostate Problems
☐ Impotence
☐ Kidney trouble
☐ Menstrual Problems, PMS
☐ Pregnant (now)
☐ Bedwetting
☐ Ear infections
☐ Varicose Veins
☐ AIDS, HIV