

SOWERS CHIROPRACTIC CENTER

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

Date _____

Name _____ Social Security _____ Home Phone _____

Address _____ City _____ Zip Code _____

Age _____ Birth Date _____ Marital: M S D W How Many children? _____ Email _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Insured's name if patient is a dependant _____ Social Security _____

Name of Insurance Company _____ Address _____

Name of Spouse _____ Birth Date _____ Occupation _____

Employer _____ Address _____

Patient's nearest relative or friend (not living at the same address) _____ Phone _____

Address _____

Referred by _____

Is condition due to injury or sickness arising out of patient's employment? _____

Date symptoms appeared or accident happened: _____ Have you lost any days from work? _____

Patient ever had same or similar condition? Yes No If yes, when and describe _____

Date of last physical examination: _____ Female: Are you pregnant? _____

What operations have you had? _____

Serious illnesses? _____ Fractured bones? _____

Have you ever been under Chiropractic Care? Yes No Doctor's name _____

Payment: Cash Check Visa/Mastercard

Have you ever suffered from:

- | | | | | | |
|---|--|--|--|------------------------------------|--|
| <input type="checkbox"/> allergy | <input type="checkbox"/> sciatica | <input type="checkbox"/> venereal disease | <input type="checkbox"/> pleurisy | Tingling or numbness in: | |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> scoliosis | <input type="checkbox"/> hay fever | <input type="checkbox"/> swelling of ankles | <input type="checkbox"/> shoulders | <input type="checkbox"/> hips |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> swollen joints | <input type="checkbox"/> sinus infections | <input type="checkbox"/> cancer | <input type="checkbox"/> arms | <input type="checkbox"/> legs |
| <input type="checkbox"/> headaches | <input type="checkbox"/> colon trouble | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> varicose veins | <input type="checkbox"/> elbows | <input type="checkbox"/> knees |
| <input type="checkbox"/> loss of sleep | <input type="checkbox"/> diarrhea | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> bed-wetting | <input type="checkbox"/> hands | <input type="checkbox"/> feet |
| <input type="checkbox"/> ulcers | <input type="checkbox"/> difficult digestion | <input type="checkbox"/> pain over heart | <input type="checkbox"/> frequent urination | Are you wearing: | |
| <input type="checkbox"/> numbness | <input type="checkbox"/> nausea | <input type="checkbox"/> poor circulation | <input type="checkbox"/> kidney infection or stone | | |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> asthma | <input type="checkbox"/> rapid heartbeat | <input type="checkbox"/> prostate trouble | heel lifts | <input type="checkbox"/> yes <input type="checkbox"/> no |
| <input type="checkbox"/> bursitis | <input type="checkbox"/> deafness | <input type="checkbox"/> slow heartbeat | <input type="checkbox"/> cramps | arch supports | <input type="checkbox"/> yes <input type="checkbox"/> no |
| <input type="checkbox"/> foot trouble | <input type="checkbox"/> ear noises | <input type="checkbox"/> anemia | <input type="checkbox"/> excessive menstrual flow | | |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> enlarged thyroid | <input type="checkbox"/> stroke | <input type="checkbox"/> irregular cycle | | |
| <input type="checkbox"/> neck pain or stiffness | <input type="checkbox"/> eye pain | <input type="checkbox"/> chest pain | <input type="checkbox"/> diabetes | | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> failing vision | <input type="checkbox"/> difficult breathing | <input type="checkbox"/> polio | | |

PLEASE PRINT

Purpose of this appointment (Major complaint) _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? yes no constant comes and goes

Is this condition interfering with your work sleep daily routine other

How long has this been going on? _____

Other Doctors seen for this condition. _____

Have you been treated for any health conditions by a physician in the last year? yes no

If yes, describe _____

What medications are you taking? _____

Family doctor's name _____ address _____

Send a report? () yes () no

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature _____ Date _____

Guardian or spouse's signature authorizing care _____ Date _____

Information taken by _____ Date _____

Notes: _____

