Baker ChiropracticClinic

Welcome,

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Patient Information

Name_____Date_____SS#_____
Address_____City_____State_____Zip_____
Home Phone_____Work Phone_____Birth Date_____
Are you: Minor___ Married___ Divorced___ Widowed___ Single___ Separated___
(Your Age)_____ Number of children_____
Your employer_____Occupation_____
Business address_____City_____State_____Zip_____
Spouse's or parent name_____Workplace_____Work phone_____
Person to contact in case of emergency_____Phone_____
Whom may we thank for referring you to us?_____

Responsible Party

Name of person responsible for this account_____
Relationship to patient_____Phone#_____
Address_____City_____State_____Zip_____
Name of employer_____Work phone_____

Insurance Information

Insured Name_____D.O.B._____Relationship to patient_____
Address_____City_____State_____Zip_____
Insurance Co._____Is this an accident case?_____

Daily Habits

What type of exercise do you perform on a daily basis?____None____Moderate___Heavy
What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer)

_____
What vitamins do you currently take?_____
What kind of other nutritional supplements do you take(if any)?_____
Do you smoke?____No____Yes How much per day?_____
How much liquor do you consume on a weekly basis?_____
How much coffee or caffeinated beverages do you consume on a daily basis_____

TURN OVER

Symptoms

Reason for visit_____

When did you first notice symptoms_____

Is this condition getting progressively worse?_____

Where specifically is the problem(s) located?_____

Which activities are difficult to perform?____Sitting____Standing____Walking____Bending
____Lying down____Other

Type of pain: ___Sharp___Dull___Throbbing___Numbness___Aching___Shooting___Burning
___Tingling___Cramps___Stiffness___Swelling___Other

Rate the severity of your pain: 1 2 3 4 5 6 7 8 9 10 (1, mild or discomfort, to 10 severe

Is the pain constant or does it come and go?_____

What treatment have you already received for your condition?

___Medication ___Surgery ___Physical Therapy ___Other_____

Have you had previous chiropractic care?____Yes____No If yes, Date of care_____

Name and address of other doctor(s) who have treated you for your condition:

_____

Health History

Check only those conditions which are applicable:

__AIDS/HIV	__Cataracts	__Hepatitis	__Osteoporosis
__Alcoholism	__Chemical Dependency	__Hernia	__Pacemaker
__Allergy Shots	__Chicken Pox	__Herniated Disc	__Parkinson's Disease
__Anemia	__Depression	__High Blood Pressure	__Pinched Nerve
__Anorexia	__Diabetes	__High Cholesterol	__Pneumonia
__Appendicitis	__Emphysema	__Kidney Disease	__Polio
__Arthritis	__Epilepsy	__Liver Disease	__Prostate Problems
__Asthma	__Fractures	__Measles	__Prosthesis
__Bleeding Disorders	__Glaucoma	__Migraine Headache	__Psychiatric Care
__Breast Lump	__Goiter	__Miscarriage	__Rheumatoid Arthritis
__Bronchitis	__Gonorrhea	__Mononucleosis	__Rheumatic Fever
__Bulimia	__Gout	__Multiple Sclerosis	__Scarlet Fever
__Cancer	__Heart Disease	__Mumps	__Stroke

Other_____

Dates of last exams_____

(Women) Are you pregnant? ___Yes ___No Taking birth control pills? ___Yes ___No

List any types of surgeries which you have had and the dates which they occured:

_____

_____

Please list all medications you are currently taking:_____

Allergies:_____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____Date_____