

DATE: _____

BULLER CHIROPRACTIC CLINIC
CONFIDENTIAL PATIENT INFORMATION
(Please Print)

ID# _____

Full Name: _____

Name of Wife, Husband, or Guardian: _____

Address: _____

Home Phone #: (____) _____
Residence and Mailing City State Zip
SS#: _____

Cell Phone #: (____) _____

Email Address: _____ Driver's License #: _____

Birth Date _____ # of Children _____ Pregnant? _____

Occupation: _____ Work Phone #: (____) _____

Employer's Name/Address: _____

Spouse's Occupation/Employer: _____

Name & Address of Nearest Relative: _____ Phone # (____) _____
(Not living with you)

Who may we thank for referring you to us? _____

List Medical Doctors consulted with in the past year:

1. Name: _____ Address: _____

When: _____ What was the diagnosis? _____

2. Name: _____ Address: _____

When: _____ What was the diagnosis? _____

Family Doctor: _____ Address: _____

Date of last physical examination: _____

Have you ever been under chiropractic care before? _____

List your problems or complaints in order of severity of pain	Date started, or for how long	If you've had condition before, when?
1.		
2.		
3.		
4.		

Have you found anything that makes your problem better (rest, morning, evening, certain positions...)?

YES NO If yes, explain: _____

Have you found anything that makes your problem worse (rest, morning, evening, certain positions...)?

YES NO If yes, explain: _____

Does your condition/pain awaken you from sleep? YES NO If yes, explain: _____

What position do you sleep in (on stomach, on back, on side...)? _____

Does your condition/pain effect your work activities? YES NO If yes, explain: _____

Have you had any time loss from work or school? YES NO If yes, explain: _____

List any medications you are taking:

- 1. Drug _____ Condition _____
- 2. Drug _____ Condition _____
- 3. Drug _____ Condition _____
- 4. Drug _____ Condition _____

List any surgeries: (Please include all types)

- 1. Type _____ When _____ Doctor _____
- 2. Type _____ When _____ Doctor _____
- 3. Type _____ When _____ Doctor _____

List any automobile accidents, sports injuries, or falls (especially those related to your present problems).

- 1. Type _____ When _____ Hospitalized? YES NO
- 2. Type _____ When _____ Hospitalized? YES NO
- 3. Type _____ When _____ Hospitalized? YES NO

NOTE: If you have RECENTLY been involved in an accident or injury, please request and fill out our accident report form, which may be obtained at the front desk.

Numbness in: _____ Arms R L _____ Hands R L _____ Legs R L _____ Feet R L	Pins and Needles in: _____ Arms R L _____ Hands R L _____ Legs R L _____ Feet R L	DR'S COMMENTS:
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PLEASE CIRCLE THE FOLLOWING CONDITIONS YOU MAY HAVE OR HAVE HAD:

- | | | | | | |
|--------------|----------------|-----------------|--------------------|---------------------|-----------------------------|
| ADD/ADHD | Depression | Gout | Menstrual Cramps | Pneumonia | Twitching of Face |
| Alcoholism | Diabetes | Hay Fever | Midback Pain | Polio | Whooping cough |
| Allergies | Diarrhea | Headaches | Migraine | Rheumatic Fever | Light Bothers Eyes |
| Arthritis | Dizziness | Heart Attack | Miscarriage | Ringing in ears | Pains in Arms/Hands |
| Asthma | Ear Infections | HIV | Multiple Sclerosis | Shortness of breath | Pains in Legs/Feet |
| Back Pain | Eczema | Intestinal Gas | Mumps | Sinus trouble | Inflamed Throat |
| Backaches | Emphysema | Irritability | Neck Pain | Stomach trouble | Irregular Periods |
| Cancer | Epilepsy | Kidney Trouble | Nervousness | Stroke | Arteriosclerosis |
| Chest Pains | Fainting | Loss of Balance | Neuritis | Swollen Joints | High Blood Pressure |
| Cold Sweats | Fatigue | Low Blood Sugar | Nose Bleeds | Thyroid Problems | Tightness of Shoulders/Neck |
| Constipation | Gall Bladder | Measles | Painful Joints | Tuberculosis | |

DUE TO THE CONSTANT CHANGE IN INSURANCE, IT IS NO LONGER AN EASY JOB TO INTERPRET EACH INDIVIDUAL POLICY.

*** I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Buller Chiropractic Clinic may prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Buller Chiropractic Clinic will be credited to my account upon 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. ***

Name of person responsible for payment: _____

Do you have insurance that covers Chiropractic Care? YES NO

If yes, Name of Insurance Company: _____ Policy #: _____

Primary Insurer's Name _____ S.S. #: _____

D.O.B.: _____/_____/_____

Patient's signature _____ Date: _____

Guardian or Spouse's Signature _____ Date: _____

Information taken by: _____ Date: _____