DATE: _____ ID#_____

CONFIDENTIAL PATIENT INFORMATION

Full Name: _____ Name of Spouse or Guardian: _____

Address: _____

Primary Phone #:(_____) _____ Email Address: _____

Date of Birth: _____ # of Children: _____ Pregnant? YES NO N/A

Occupation: _____ Company Name: _____

Emergency Contact: _____ Phone#:(____) _____

Are there any individuals (spouse, parent, etc.) with whom you would like to allow access to your health information if requested?

If so, please list: _____

How did you find out about our office? _____

Have you ever been under chiropractic care before? YES NO: When? _____ Who? _____

List any medical doctors consulted within the past year:

1. Name: _____ Reason: _____
2. Name: _____ Reason: _____

Family Doctor's Name: _____

Please describe your primary health concerns (i.e. low back pain, headaches, neck pain, etc…) in order of severity, along with a description of the pain, when it started, and any injury that may have caused it):

1. _____
2. _____
3. _____

Have you had pain like this before? YES NO If yes, explain:

_____

Is there a family history of these health concerns? YES NO If yes, explain: _____

_____

Have you experienced any numbness, tingling, or pins and needles sensations in your arms or legs? (Please explain)

_____

What relieves your symptoms (i.e. rest, ice, heat, medication, certain positions…)?

_____

What aggravates your symptoms (i.e. bending, lifting, exercising, walking, standing, etc…)?

_____

Does your condition/pain affect your sleep? YES NO

Does your condition/pain affect your work activities? YES NO

Have you had any time loss from work or school? YES NO

Continued on back of page

BULLER CHIROPRACTIC

Do you have any allergies to any food products or medications? YES NO If yes, please list: _____

_____

List any medications or supplements you are currently taking:

_____

List any surgeries you have had in the past: (Please include all types)

1. Type: _____ When: _____
2. Type: _____ When: _____
3. Type: _____ When: _____

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

1. Type: _____ When: _____
2. Type: _____ When: _____
3. Type: _____ When: _____

PLEASE CIRCLE THE FOLLOWING CONDITIONS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST:

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 CHANGES IN INSURANCE, IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR OWN POLICY AND COVERAGE.

*** I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself . If an insurance company denies services at this office, I understand that I am ultimately responsible for charges rendered for care at this office. ***

Primary Insured's Name (If different than yours): _____ DOB: _____/_____/_____

Patient's Name (Printed): _____ ID # (For office use only): _____

Patient Signature: _____ Date: _____

Parent or Guardian's Name: _____ Date: _____

Information Taken By: _____ Date: _____