PAYNE CHIROPRACTIC

PATIENT INFORMATION

Date: _____

SSN: _____

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Date of Birth: _____ Age: _____

Gender: □ Male □ Female □ _____

Email: _____

Phone Number: _____
□ Home □ Work □ Cell

□ Employed □ Unemployed □ Retired □ Student

Occupation: _____

Employer/School: _____

□ Married □ Single □ Widowed □ Divorced □ Minor

INSURANCE

Insurance Company: _____

Subscriber ID#: _____

Group #: _____

Insured Name: □ Self □ _____

Secondary Insurance? □ No □ Yes, complete below

Insurance Company: _____

Subscriber ID#: _____

Group #: _____

Insured Name: □ Self □ _____

ACCIDENT INFORMATION

If visit is due to an accident, complete below:

Type of accident: □ Auto □ Work □ _____

Accident date: _____

Attorney/Claim Adjustor info: _____

_____

How did you hear about us? _____

IN CASE OF AN EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Home Number: _____ Cell Number: _____

CONDITION INFORMATION

Describe your pain: _____

When did it start? _____

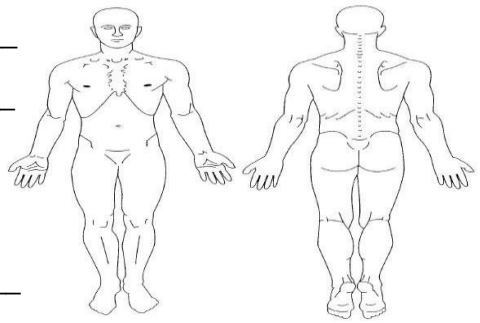
What caused it? _____

Is your condition getting worse? □ Yes □ No □ Unknown

Rate your pain on a scale of 0-10: _____

How often do you have the pain? _____

Mark an X where you hurt



Is your pain? □ aching □ stiffness □ shooting □ cramping □ dull □ sharp □ numbness/tingling □ _____

Does your pain interfere with? □ work □ sleep □ daily routine □ recreation □ _____

What makes it worse? □ walking □ driving □ sitting □ bending □ standing □ lying down □ turning □ exercising

What makes it better? □ ice □heat □ rest □ stretching □ medicine □ massage □ _____

Have you tried any other treatment? □ No □ Yes, _____

REVIEW OF BODY SYSTEMS

Are you currently experiencing?

- □ Fatigue
- □ Unexplained changes in weight
- □ Changes in vision or hearing
- □ Mouth or throat sores
- □ Swelling in hands or feet
- □ Leg pain with walking
- □ Shortness of breath
- □ Wheezing
- □ Difficulty swallowing
- □ Constipation or diarrhea
- □ Changes in bowel or bladder habits
- □ Fainting/passing out
- □ Involuntary movement/tremors
- □ New or changes to moles/skin lesions
- □ Anxiety, depression, insomnia
- □ Easily bruised
- □ Unexplained swollen areas
- □ Joint swelling
- □ Other _____

HEALTH HISTORY

Have you ever been to a Chiropractor? □ No □ Yes, why? _____

Check if you have/had any of the following:

- □ Asthma
- □ Bleeding disorder
- □ Cancer
- □ Diabetes
- □ Esophageal varices
- □ Gout
- □ Heart disease
- □ Hepatitis, liver disease
- □ Hernia
- □ Herniated disc
- □ High Blood Pressure
- □ High cholesterol
- □ HIV/AIDS
- □ Kidney disease
- □ Multiple Sclerosis
- □ Osteoarthritis
- □ Osteopenia
- □ Pacemaker
- □ Pinched nerve
- □ Prostate problems
- □ Prosthesis
- □ Psychiatric care
- □ Rheumatoid arthritis
- □ Stroke/ TIA
- □ Thyroid problems
- □ Tumor/growth
- □ Ulcers
- □ Other _____

Are you pregnant? □ No □ Yes, due date _____

Do you exercise? □ None □ Few times per month □ Few days per week □ Daily

How do you sleep? □ Back □ Side □ Stomach

What is your work activity? □ sitting □ standing □ lifting □ computer work □ light labor □ heavy labor

Do you smoke/vape/dip? □ No □ Yes, how much? _____

What is your stress level? □ Light □ Moderate □ High Reason? _____

Please list any of the following:

Past falls, head injuries: _____

Broken bones: _____

Prior Surgeries: _____

Allergies: _____

Medication, vitamins, supplements: _____

_____