Confidential Patient Information

Highland Family Chiropractic, 770.565.8151

Please complete all questions to the best of your ability. If you need help, please ask the receptionist.
PLEASE PRINT!

Name____ Today's Date_________________________
Address____ City/ State/ Zip_______________________
Date of Birth_________________ Age_______ Marital Status: S M D W, No. of Children______
Home Phone #_____________________________Work Phone #_________________________________
Cell Phone Number__________________________ E-Mail Address______________________________
Cell Phone Carrier: **ATT, VERIZON, SPRINT, T-MOBILE, METRO PCS, BOOST, VIRGIN, OTHER**______________
Name of Spouse or Parent____
Your Employer_________________________________Occupation____________________________
Who referred you______________________________ Your Hobbies______________________________
Height _________ Weight _________ Right or Left Handed _______________________________________
Emergency Contact (Name/Phone)_____________________________________ ________________
Do you have health insurance? Yes_____ No_____ Name of Insurance_______________________
Policy #______________________________ Does your spouse have health insurance at work? Y /N
Are you covered under this insurance? Y / N If so, Spouse's Name__________________________
Spouse's Date of Birth_______________________ Name of Insurance__________________________
Policy #______________________________ Spouse's Social Security #___________________________

Name of Previous Chiropractors___________________________________ Last Visit_______________
How long were you receiving Chiropractic Adjustments__________________________

Describe the major complaints that bring you to our office___________________________________
____
Have you seen any other providers for this condition? Y / N, What type?______________________
Have you had this problem in the past? Y / N, If yes when?_______________________________

Have you been in an Auto Accident? Past Year___ Past 5 years___ Over 5 Years___ Never___
Is your condition due to an accident? Y / N Date of Accident_____________________
Type of accident? Auto_____ Work/on Job_____ At Home_____ Other _______________________

Were you ever knocked unconscious?____
What fractures or broken bones have you had? (include dates)______________________________
____

SURGERY

What major surgery have you had (include dates)_______________________________________
____
What minor surgery have you had? (tonsils, appendix, wart/cyst removal, dental extraction)
____

MEDICATION (Please List)

Present Prescription Drugs ____
____
Over-the-counter Drugs ____
____

THERAPY

Are you presently under any therapeutic care? (what type) ________________________________

What therapeutic care have you been under in the past (radio, chemo, physio, electro, etc., include dates) ____

____

CURRENT HEALTH

How would you describe your current health?______________ Family's Health?_______________

Describe your: Vision____________ Hearing_________________ Coordination_______________

Do you use any of the following: Tobacco Alcohol Coffee/Tea Cola Milk

Level of stress in your life: Mild Moderate Extreme

Do you currently exercise? Y/N How often: DAILY WEEKLY MONTHLY

Do you purchase any of the following: **Bottled Drinking Water:** Y / N **Vitamins:** Y / N

Health Food Products: (organic products, etc.) Y / N

Please check any of the following that give you difficulty or you have had recently.

__Headache	__Poor digestion	__Earache	__Chest pain
__Dizziness	__Belching or Gas	__Ear noises	__Difficulty breathing
__Loss of Sleep	__Nausea	__Ear discharges	__Chronic cough
__Fatigue	__Constipation	__Nose bleeds	__Spitting blood
__Night sweats	__Diarrhea	__Sore throat	__Frequent urination
__Nervousness	__Colon trouble	__Hoarseness	__Painful urination
__Loss of weight	__Gall Bladder trouble	__Hay Fever	__Blood in urine
__Wheezing/Asthma	__Liver trouble	__Frequent colds	__Kidney infection
__Allergies	__Rapid heart	__Thyroid problems	__Bed wetting
__Numbness/Tingling	__Slow heart	__Tonsillitis	__Prostate trouble
__Weak muscles	__High blood pressure	__Sinus trouble	__Painful periods
__Twitching	__Low blood pressure	__Skin problems	__Irregular cycles
__Stiff/Painful neck	__Heart trouble	__Itching	__Hot flashes
__Backache	__Swelling of ankles	__Bruising easily	__Swollen joints
__Poor circulation	__Eczema	__Miscarriage	__Hip pain
__Foot troubles	__Stroke/TIA	__Psoriasis	__Low back pain
__Mid back pain	__Hernia	__Excessive dry skin	

Have you had any of the following diseases?

__Appendicitis	__Anemia	__Heart disease	__Arthritis
__Pneumonia	__Measles	__Goiter	__Epilepsy
__Rheumatic fever	__Mumps	__Pleurisy	__Mental disorder
__Polio	__Chicken Pox	__Alcoholism	__Venereal disease
__Tuberculosis	__Diabetes	__Cancer	__Whooping cough

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non covered. 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_________________________

Parent or Guardian Signature________________________________ Date_______________________