Superior Family Chiropractic & Wellness

Patient Information – Please Print

GENERAL INFORMATION

Patient Name: _____ Nickname: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Email: _____

Date of Birth: _____ Sex: M / F Married: ___ Single: ___ Divorced: ___ Widowed: ___

Social Security #: _____ Occupation: _____

Employer: _____ Phone: _____

Full Time: ___ Part Time: ___ Retired: ___ Not Employed: ___ Student: ___

Spouse/Significant Other's Name: _____ Their Employer: _____

Referred by _____

PATIENT HISTORY

PLEASE FILL ALL SPACES (all information is confidential)

Major Complaint: _____

_____

How is this affecting daily activities? _____

What is it keeping you from doing? _____

How long have you had this condition? _____ Date of onset: _____

Have you lost work days? _____ How many: _____ Have you had this similar condition before? _____

If so how long? _____ Was the injury accident related? _____ Auto: ____ Work: ___ If so when: _____

Have you had previous Chiropractic Care? _____ Doctor's Name: _____

When was your last adjustment? _____ What was the reason for your visit here? _____

Why are you changing Chiropractors? _____

What surgeries have you had? _____

List any medications you are now taking (prescription/non prescription): _____
_____

Name of other doctors you have seen for this condition: _____

What are your health goals? _____

Do you exercise? ____ What do you do? _____

Do you feel you are as healthy as you could be? _____ What is your lack of health keeping you from doing or enjoying? _____

Do you have a lot of stress in your life? ____ In what way? _____

Please check any of these symptoms you have experienced in the last 12 months:

___ Fractured Bones ___ Auto Accidents: __ 0-1 years ago __ 1-5 years ago __ 5+ years

Other accidents/falls: _____

__Arthritis	__Mood changes	__Numbness	__Diabetes
__Neck pain or stiffness R/L	__Foot trouble	__Convulsions/epilepsy	__Jaw pain (TMJ) R/L
__Chest pain	__Skin problems	__Heart problems	__Cancer
__Numbness, tingling, pain	__Stroke	__Frequent colds, flu	__Depression
In arms, hands, fingers R/L	__High/Low BP	__Varicose veins	__Irritable
__Difficulty in excessive	__Liver Trouble	__Gall Bladder	__Digestive trouble
standing, sitting, bending,	__Anemia	__Shoulder pain R/L	__Ulcers
lifting, twisting.	__Allergies, sinus	__Dizziness	__Under Stress
__Ringing in ears, R/L	__Hemorrhoids	__Hearing loss	__Eating disorder
__Trouble sleeping	__Prostate Problems	__Trouble concentrating	__Impotence
__Upper, lower, mid back	__AIDS/HIV	__Hip pain R/L	__Kidney trouble
pain/stiffness	__Headaches	__Pain with cough/sneeze	__Ear infections
__Menstrual problems	__Bedwetting	__Learning disabilities	

Any chance you are pregnant now: _____ Due date: _____ Last period? _____

Release and Assignment

I authorize release of any information necessary to process my insurance claims and assign request payment directly to my physicians.

Patient Signature: _____ Date: _____