PATIENT CONTACT INFORMATION

Today's Date_____________________

Name ____
First Name Middle Initial Last Name

What name would you like for us to call you in the clinic? ____

Address ____

City ________________________________State _________________ Zip __________________

Preferred Phone # for receiving calls from clinic staff: (__________)________________--_____________________

May we leave a message on this phone line? Yes / No

Birth date: ____________________ Age __________ Male / Female

Social Security #: __________________________ Driver's License #: _____________________________

e-mail: ____

Preferred language: English / Español / Other ________ Race _______________ Ethnicity ______________

Employer ___________________________________ Work Phone: __________________________

Employer's Address ___________________________City __________________State __________Zip _____

Occupation: _______________________________

Marital Status: M S D W Sep Spouse: _____________ Children: _____________________________________

EMERGENCY CONTACT INFORMATION

Person's Name: ____

Home Phone: _________________Cell Phone: ____________________Work Phone: __________________

Address ___________________________________City __________________State __________Zip _____

Your relationship to this person: _________________________________

REFERRAL INFORMATION

Referred by: (name of person or source)___________________________Relationship ___________________

PRIMARY CARE PHYSICIAN

Your medical doctor's name: ___________________________________ Phone: ________________

Address ___________________________________City __________________State __________Zip _____

INSURANCE INFORMATION

Your insurance company ________________________ Policy/Group # ________________________

Primary Insured ______________________ Relationship ______________ Date of Birth____________

HEALTH INFORMATION

PURPOSE OF VISIT

Specific Complaints: ____

____

How long have you had this condition? ____

Have you ever had a similar condition in the past? __yes __no If yes, please explain: ______________________

____

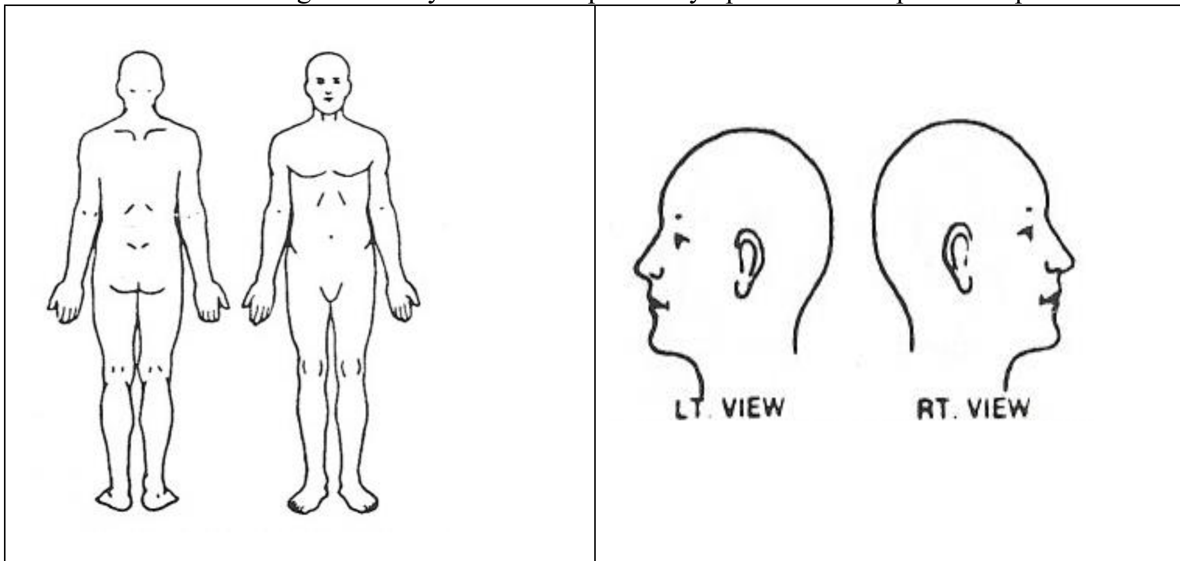
Is your condition due to an accident or injury? __yes __no If yes, is it job related? __yes __no

Do you know what caused this condition? __yes __no If yes, please explain: ____________________________

____

If no, what were you doing when you first noticed symptoms? ____

Please use these drawings to mark your areas of pain or symptoms. Be as specific as possible.



Check all that apply: [ ] mild [ ] moderate [ ] severe [ ] dull ache [ ] sharp [ ] burning

[ ] numbness or tingling [ ] constant [ ] comes and goes

When does it hurt? [ ] morning [ ] night [ ] sitting [ ] standing [ ] lying [ ] other _____________

Check if the pain interferes with your: [ ] work [ ] sleep [ ] daily routine [ ] recreation

What makes it feel better?____

Is your condition: [ ] getting progressively worse [ ] getting better [ ] staying the same

Any other symptoms or concerns not already mentioned? ____

PRESENT TREATMENT

Have you seen another doctor for this? __yes ___no Name: ____

Have you had X-rays? __yes __no Have you had an MRI? __yes __no

What type of treatment did you receive? ____

Are you treating yourself at home? __yes __no How? ____

Are you taking any medicines for this now? __yes __no List: ____

PAST MEDICAL HISTORY

Family Physician (PCP): ________________________Most recent physical exam: ______________

Have you ever had chiropractic care? __yes __no Name of DC: ________________________________

Please list past accidents and illnesses: ____

____

Please list any surgeries you have had: ____

____

Do you have allergies? __yes __no List: ____

Please list any other medical conditions you have, and any medications that you take: ______________________

____

____

____

Do you have: [ ] Hepatitis [ ] Diabetes [ ] Heart Disease [ ] HIV [ ] None of these

Have you gained or lost weight recently? __yes __no If yes, check one of the following and explain:

□ gained □ lost ____

Any other significant health history not already mentioned: ________________________________

____

SOCIAL HISTORY

Do you smoke? [ ] yes How much? _________ [ ] no, never [ ] no, I quit ___________ ago

Drink coffee or other caffeinated beverages? [ ] yes ______________________________ [ ] no

Drink alcohol? [ ] yes ____ [ ] no

What are your hobbies and activities? ____

How much do you exercise? ____

GOALS and EXPECTATIONS (for discussion purposes)

Right now, my pain is (circle one number):

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Possible Pain

Right now, my pain is keeping me from: ____

____

With treatment, I think my pain can be reduced to (circle one number):

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Possible Pain

I think I can get well in: [ ] one day [ ] one week [ ] one month [ ] two months [ ] six months

I am also interested in: [ ] Acupuncture [ ] Physical Therapy [ ] Exercise Instruction

[ ] Spinal Decompression Therapy [ ] Herbal and Homeopathic Medicines

[ ] a Diet Plan [ ] Nutritional Supplements

[ ] other ______________________________________

OUR PROMISE

We, the doctor and staff members of the Bronson Clinic, will do our best to find the cause or causes of your condition, and to do our best to explain our findings in terms that you will understand. We will tell you exactly what we feel that you need, and then cheerfully provide you with the finest care available.

Following your examination and case presentation by the doctor, you will choose a care plan that fits your schedule and your budget. We want you to be so satisfied with the Bronson Clinic and our services that you will eagerly refer others to us for chiropractic care.

Is there *anything else about your health* that you want to discuss with the doctor?