Confidential Patient Information

General Information Today's Date_______________

Name: ______________________________ Date of birth________________
Address ______________________________ City__________________________
State:__________ Zip: _________ E-mail Address:____________________
Home Phone: ____________________ Work Phone:_____________________
Cell Phone:______________________ -Circle the best# to reach you.
Social Security #______________________ Age: ______ Male___ Female___
Marital Status:_______ , Name &age of children
____
Name, phone # and Relation of an Emergency contact:
____
Your Occupation:__________________________ Employer:_____________
Referred to this office by:____
Payment of services will be by: Self pay______ Health Insurance_________
Automobile Insurance__________
Name of Insurance Co:____
Insured's Name:______________________ Relation:__________________
Insured's SS#:_____________________ Insured's DOB________________
Insured's Address:____
Policy or Claim #:____
Group Name Or #_______________________ Ins Co. ph#:______________
Is there a secondary Ins. Co.? Y:___N:____ Name:____________________
As a courtesy we will file your insurance paper work but, as a chiropractic provider our relationship is with you not your insurance company.

Medical History: Check any of the following that you have had in your life And approximate age it started :

Pneumonia	Mumps	HIV
Rheumatic Fever	Small Pox	Pleurisy
Polio	Chicken Pox	Arthritis
Tuberculosis	Diabetes	Epilepsy
Whooping Cough	Cancer	Mental Disorders
Anemia	Heart Disease	Lumbago
Measles	Thyroid	Eczema

Intake: Check off any of the following that you use:

Coffee:____ Tea:____ Alcohol:____ Cigarettes/Tobacco:_____ Sugar:____

Recent Medical History: Check any of the following you have had in the past 6 months

Musculo-skeletal

Low back pain ___: ____________
Pain between shoulders ___: ____________
Neck pain ___: ____________
Arm pain ___: ____________
Joint Pain/Stiffness ___: ____________
Walking problems ___: ____________
Difficult chewing/Clicking jaw ___: ____________
General stiffness ___: ____________

C-V-R

Chest Pain ___: ____________
Short Breath ___: ____________
Blood pressure problems ___: ____________
Irregular heart beat ___: ____________
Heart problems ___: ____________
Lung problems/congestion ___: ____________
Ankle swelling ___: ____________
Stroke ___: ____________

Gastro-intestinal

Poor/Excessive Appetite ___: ____________
Excessive thirst ___: ____________
Frequent Nausea ___: ____________
Vomiting ___: ____________
Diarrhea ___: ____________
Constipation ___: ____________
Hemorrhoids ___: ____________
Liver Problems ___: ____________
Gall Bladder Problems ___: ____________
Weight trouble ___: ____________
Gas/Bloating after meals ___: ____________
Heartburn ___: ____________
Black/Bloody stool ___: ____________
Colitis ___: ____________

Females Only

When was your last period? ____________
Are you pregnant? ____________

Nervous System

Nervous ___: ____________
Numbness ___: ____________
Paralysis ___: ____________
Dizziness ___: ____________
Forgetfulness ___: ____________
Confusion/Depression ___: ____________
Fainting ___: ____________
Convulsions ___: ____________
Cold/Tingling Extremities ___: ____________
Stress ___: ____________

General Code

Fatigue ___: ____________
Allergies ___: ____________
Loss of sleep ___: ____________
Fever ___: ____________
Headaches ___: ____________

EENT

Vision problems ___: ____________
Dental problems ___: ____________
Sore throat ___: ____________
Ear Aches ___: ____________
Hearing Difficulty ___: ____________
Stuffed Nose ___: ____________

Genito-urinary

Bladder Trouble ___: ____________
Painful/Excessive Urination ___: ____________
Discolored urine ___: ____________

Male/Female

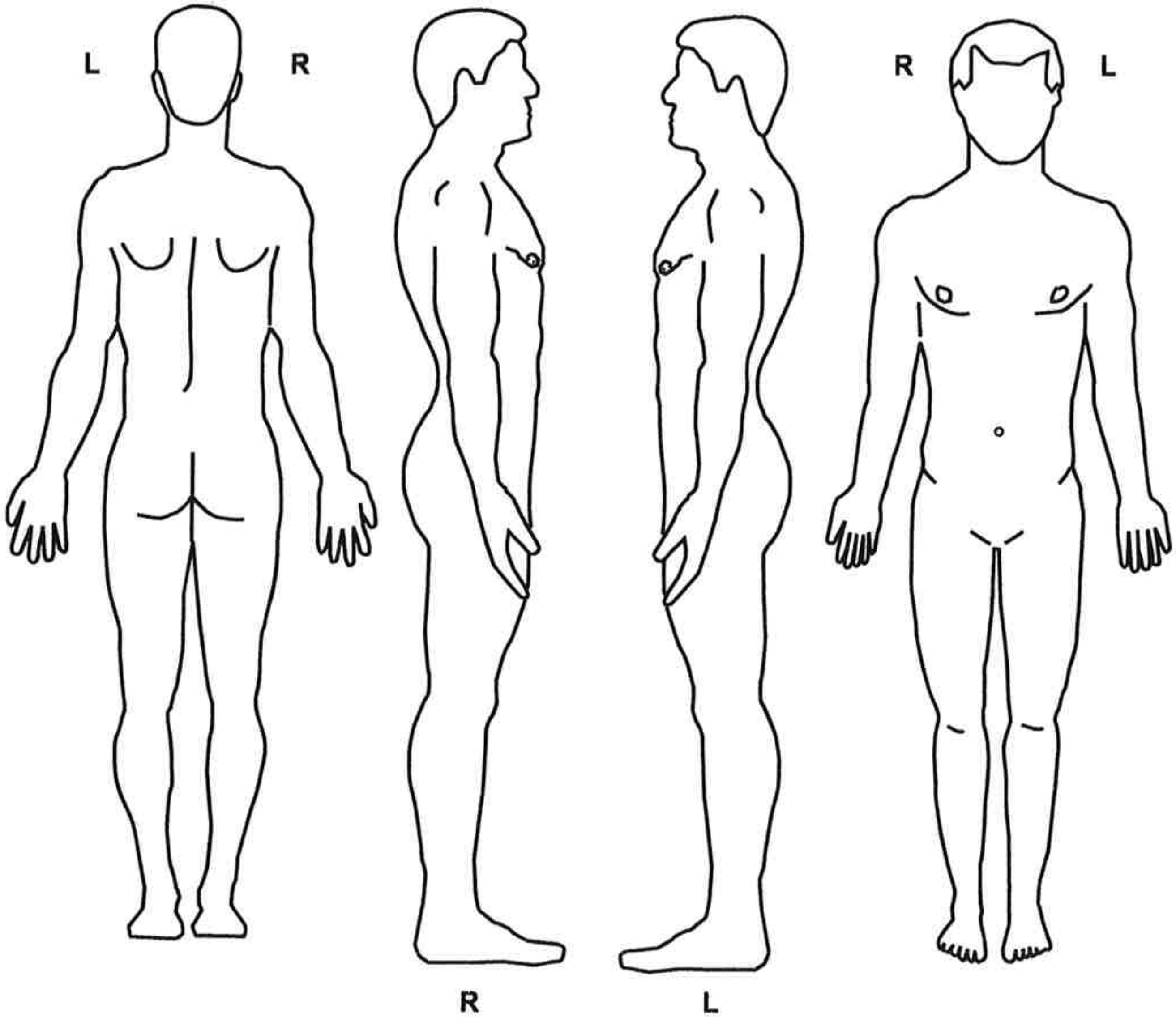
Menstrual Irregularity ___: ____________
Menstrual Cramps ___: ____________
Vaginal Pain/Infection ___: ____________
Breast Pain/Lumps ___: ____________
Prostate/Sexual Dysfunction ___: ____________

Family History

Do any of your family member have a similar problem? ____________ Who? ____________

PAIN DRAWING

Name ______________________________ Date __________



Mark as follows:
A - Ache B - Burning N - Numbness P - Pins & Needles
S - Stabbing O - Other - Describe ______________________________

Please describe your present complaints. (Why you are here today)
Please rate complaint (1 to 10 ; 10 being the worst)

1. ______________________________ : ______
2. ______________________________ : ______
3. ______________________________ : ______
4. ______________________________ : ______

When did your complaint start?__________________
When, during the day, do your symptoms seem the worst?
____
Do they come and go ?________ or are they persistent?________
How long do they last? (Explain) __________________
____
Have you ever had this before? ______________ when?______
What do you think is causing the problem? ____________
____
Have you seen any other doctor about this same problem? ______
Who? ______________________________
What did they say the problem was? ______________
____
What type of treatment did they do?______________
What else have you done to try to help the problem?__________
____
What has seemed to help the most so far?______________
What activities aggravate your problem?______________

I understand and agree that health and insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that May Family Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the doctors office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the doctor to treat my condition as he deems appropriate. It is understood and agreed the amount paid the doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees the he/she is responsible for all bills incurred at this office.

Patient's signature______________________________ Date__________
Consent to Treat a Minor ______________________________ Date __________