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Today's Date__________________ **Patient Number** ____________

CONTACT INFORMATION

Name_____________________________________ Preferred to be called ___________ □ Male □ Female
Address__________________________City_______________State_____Zip_________ Birth Date:________
Home Phone________________ Cell Phone__________________ Work Phone _________________
Preferred Method of Communication(circle one): Email / Phone / Mail
E-mail __________________________SSN____________ Who Referred you to this office? _____________
Primary Doctor______________________ Marital Status: **S M D W** SPOUSE'S NAME __________________
Preferred Language _________ Race: American Indian___Asian___Black/African American___ Native Hawaiian ___White___Decline to Specify___Other Race___Ethnicity: Hispanic______ Non-Hispanic______
Occupation________________________________Employer____
Emergency Contact_____________________ Phone Number______________ Relationship______________

BILLING INFORMATION

Do you have medical insurance? □Yes □ No Insurance Company Name ____________________________
Insured's Name ______________________Relationship to patient ____________________________
Insured's DOB ______________________Insured's SS# __________________________________
Insured's Employer _________________ Insured's Employee Address_________________________
Do you have a secondary insurance? ? □Yes □ No Insurance Company Name _________________________
If you are not financially responsible for your account, who is?
Name:____ Phone:______________
Address:____

I authorize RIVER RIDGE CHIROPRACTIC to release any information pertinent to my case to my insurance carrier and to submit a claim for all services rendered by this office. I authorize and direct my insurance carrier or its intermediaries to issue payment checks directly to this office for services rendered. I understand I am financially responsible to this office for any balance not covered by this authorization. I understand that if I suspended or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. If it is ever necessary for this office to employ collections counsel, I understand that I am responsible for those collection charges. A copy of this signature is as valid as the original.

Patients Signature ____**Date** __________
Guardian or Spouse's Signature ____Date __________

CHIROPRACTIC HISTORY

Have you ever been to a Chiropractor before? □Yes □ No If yes Doctor's Name_________________________
Date of last chiropractic visit__________________ Reason for Care___________________________________
Date of last x-rays __________________________How long were you under care? ______________________

HEALTH HISTORY

Check any symptoms/medical conditions that you have had: ◊ = Previously, □ = Now

◊ □ Headaches/Migraines
◊ □ Dizziness or light-headed
◊ □ Jaw pain/clicking/ locking
◊ □ Neck pain or stiffness
◊ □ Shoulder pain
◊ □ Mid back pain
◊ □ Chest pain or cough
◊ □ Arm/hand numbness/ tingling
◊ □ Arm/hand fatigue/ weakness
◊ □ Low back pain/Sciatica
◊ □ Leg/foot numbness/ tingling
◊ □ Leg/foot fatigue/ weakness
◊ □ Leg pain with walking
◊ □ Sensitive to light
◊ □ Sensitive to sound
◊ □ Visual problems
◊ □ Hearing problems

◊ □ Memory loss/problems
◊ □ Irritability or depression
◊ □ Fatigue or loss of energy
◊ □ Trouble with balance or coordination
◊ □ Sleep problems
◊ □ Rashes (face, body, limbs)
◊ □ Joint pain or swelling
◊ □ Pain with exertion i.e. activity, climbing stairs
◊ □ Chronic Sinus
◊ □ Ear Infections
◊ □ Allergies
◊ □ Asthma
◊ □ Difficulty Breathing
◊ □ Kidney problems
◊ □ Digestion problems
◊ □ Poor circulation
◊ □ Bladder problems
◊ □ Prostate problems

◊ □ Thyroid problems
◊ □ Alcohol/Drug Abuse
◊ □ AIDS/HIV
◊ □ Epilepsy/ Fainting/Seizures
◊ □ Osteoporosis
◊ □ Osteo Arthritis/ Rheumatoid Arthritis
◊ □ Heart Attack/Stroke
◊ □ Heart Defect/Condition
◊ □ Heart Surgery/Pacemaker
◊ □ High Cholesterol
◊ □ Low/High blood pressure
◊ □ Diabetes Type 1/Type II
◊ □ Shingles
◊ □ Cancer/Chemotherapy
◊ □ Venereal disease
◊ □ Hepatitis
◊ □ Ulcers/Colitis/IBS
◊ □ Artificial Bones/Joints
◊ □ Abnormal menstrual cycle

Do you smoke □No □Yes How much?_______How long?_______Are you wearing? □Heel lifts □Arch Supports □Other Supports

List all medications/supplements/controlled substances you are taking. List any medication allergies you have.

____

List any other serious medical conditions that you have ever had:

____

List all surgical operations and years:

____

List all serious accidents with dates: (motor vehicle accidents, falls, spills or broken bones)

____

CURRENT HEALTH CONDITION

What is your major complaint?__________________________________

How long have you had this condition? _________

Have you had this or similar conditions in the past? _______________

What activities aggravate your condition?______________________

Is this condition getting progressively worse? □Yes □ No

□ Constant □ Comes and goes

Is this condition interfering with your:

□ Work □ Sleep □ Daily Routine □ Other: ____________________

Other doctors who treated this condition:

____

Please mark where it hurts