

DATE: _____

BULLER CHIROPRACTIC CLINIC
CONFIDENTIAL PATIENT INFORMATION

ID# _____

(PLEASE PRINT)

Full Name: _____ Name of Spouse or Guardian: _____

Address: _____

Residence and Mailing

City

State

Zip

Home Phone#: (____) _____ SS#: _____

Cell Phone#: (____) _____ Email Address: _____

Birth Date: _____ # of Children: _____ Pregnant? YES NO N/A

Occupation: _____ Work Phone #: (____) _____

Employer's Name: _____

Spouse's Occupation/Employer: _____

Emergency Contact: _____ Phone#: (____) _____

Are there any individuals (spouse, parent, etc.) with whom you would like to allow access to your health information if requested?

If so, please list: _____

Who may we thank for referring you to us? _____

List Medical Doctors consulted within the past year:

1. Name: _____ City: _____ Reason: _____

2. Name: _____ City: _____ Reason: _____

Family Doctor: _____ Phone: _____

Date of last physical examination: _____

Have you ever been under chiropractic care before? NO YES: When? _____ Who? _____

What complaint(s) are you having in order of severity of pain or symptom?	Was this caused by an injury?	What started your pain? When did it start? How long have you had your pain?	Describe your pain. (i.e., Dull, Sharp, constant, off/on)
1.	YES/NO		
2.	YES/NO		
3.	YES/NO		
4.	YES/NO		

Have you had pain like this before? If yes, explain: _____

Have you found anything that makes your symptoms better (rest, morning, evening, certain positions...)?

YES NO If yes, explain: _____

Have you found anything that makes your symptoms worse (rest, morning, evening, certain positions...)?

YES NO If yes, explain: _____

Does your condition/pain awaken you from sleep? YES NO If yes, explain: _____

What position do you sleep in (on stomach, on back, on side...)? _____

Does your condition/pain affect your work activities? YES NO If yes, explain: _____

Have you had any time loss from work or school? YES NO If yes, explain: _____

Do you have a history of tobacco use (cigarette, smokeless, etc.)? YES NO If yes, how much/how long? _____

Would you like information on how to quit? YES NO

Do you have any allergies to any food products or medications? YES NO If yes, please list: _____

List any medications you are taking:

- 1. _____ Condition: _____
- 2. _____ Condition: _____
- 3. _____ Condition: _____
- 4. _____ Condition: _____

List any surgeries: (Please include all types)

- 1. Type: _____ When: _____ Doctor: _____
- 2. Type: _____ When: _____ Doctor: _____
- 3. Type: _____ When: _____ Doctor: _____

List any automobile accidents, sports injuries, or falls (especially those related to your present problems).

- 1. Type: _____ When: _____ Hospitalized? YES NO
- 2. Type: _____ When: _____ Hospitalized? YES NO
- 3. Type: _____ When: _____ Hospitalized? YES NO

NOTE: If you have RECENTLY been involved in an accident or injury, please request and fill out our accident report form, which may be obtained from the front desk.

Numbness in: _____ Arms R L _____ Hands R L _____ Legs R L _____ Feet R L	Pins and needles in: _____ Arms R L _____ Hands R L _____ Legs R L _____ Feet R L	DR's COMMENTS:
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PLEASE CIRCLE THE FOLLOWING CONDITIONS YOU MAY HAVE OR HAVE EVER HAD:

- | | | | | | |
|--------------|----------------|-----------------|--------------------|---------------------|-----------------------------|
| ADD/ADHD | Depression | Gout | Menstrual Cramps | Pneumonia | Twitching of Face |
| Alcoholism | Diabetes | Hay Fever | Midback Pain | Polio | Whooping cough |
| Allergies | Diarrhea | Headaches | Migraine | Rheumatic Fever | Light Bothers Eyes |
| Arthritis | Dizziness | Heart Attack | Miscarriage | Ringing in ears | Pains in Arms/Hands |
| Asthma | Ear Infections | HIV | Multiple Sclerosis | Shortness of breath | Pains in Legs/Feet |
| Back Pain | Eczema | Intestinal Gas | Mumps | Sinus Trouble | Inflamed Throat |
| Backaches | Emphysema | Irritability | Neck Pain | Stomach Trouble | Irregular Periods |
| Cancer | Epilepsy | Kidney Trouble | Nervousness | Stroke | Arteriosclerosis |
| Chest Pains | Fainting | Loss of Balance | Neuritis | Swollen Joints | High Blood Pressure |
| Cold Sweats | Fatigue | Low Blood Sugar | Nose Bleeds | Thyroid Problems | Tightness of Shoulders/Neck |
| Constipation | Gall Bladder | Measles | Painful Joints | Tuberculosis | |

DUE TO THE CONSTANT CHANGE IN INSURANCE, IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR OWN POLICY AND COVERAGE.

*** I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Buller Chiropractic Clinic may prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Buller Chiropractic Clinic will be credited to my account upon 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 my care and treatment, any fees for professional services rendered me will be immediately due and payable. ***

Name of person responsible for payment: _____

Primary Insured's Name: _____ DOB: ____/____/____
(If different than yours)

Patient Signature: _____ Date: _____

Guardian or Spouse's Name: _____ Date: _____

Information Taken By: _____ Date: _____