In Touch Chiropractic Patient History

(Please print. All information is confidential.)

Name: ______________________________ Referred By: ______________________

Address: ______________________ City: ___________ Prov.: _______ Postal Code: ________

Preferred Phone Number: __________________ Alternate Phone Number: __________________

Preferred E-mail Address: ____

Sex: M F T Marital Status: ___________ Birthdate: _____________ # of Children: ______

Occupation: __________________________ Employer: ______________________________

Do you have extended insurance coverage? ____ Yes _____ No

FOR PRESENT CONDITIONS MARK AN 'X', FOR PAST CONDITIONS MARK AN 'O'

MUSCLE AND JOINT

_____ Neck Pain
_____Mid Back Pain
_____Low Back Pain
_____Shoulder Pain
_____Hernia
_____Spinal Curvature
_____Faulty Posture
_____Arthritis
_____Headaches

STRESS SYMPTOMS

_____Headaches
_____Dizziness
_____Numbness in hands/feet
_____Ringing in Ears
_____Blurring of Vision
_____Loss of Sleep
_____Loss of Concentration
_____Loss of Memory
_____Irritable/Nervousness
_____Depression
_____Low Energy/Fatigue

GENERAL

_____ Fever/Chills/Sweat
_____Fainting
_____Convulsions
_____Allergies
_____Skin Problems
_____Colds
_____Tremors
_____Diabetes
_____Cancer
_____Thyroid Trouble
_____Polio
_____HIV

EYES/EARS/ NOSE/THROAT

_____Deafness
_____Ear Aches
_____Sore Throat
_____Asthma
_____Tonsilitis
_____Sinus Trouble

GASTROINTESTINAL

_____Difficult Digestion
_____Belching or Gas
_____Nausea or Vomiting
_____Pain Over Stomach
_____Constipation
_____Colon Trouble
_____Liver Trouble
_____Gall Bladder Trouble
_____Heartburn
_____Diarrhea
_____Bloody Stools

URINARY

_____Painful Urination
_____Waking to Urinate
_____Blood in Urine
_____Increased Urination

RESPIRATORY

_____Chronic Cough
_____Spitting Blood
_____Chest Pain
_____Pneumonia
_____Tuberculosis

CARDIOVASCULAR

_____Rapid Heart Beat
_____Slow Heart Beat
_____High Blood Pressure
_____Low Blood Pressure
_____Pain Over Heart
_____Swelling Over Ankles
_____Heart Disease
Previous Heart Attacks? Y N
Poor Circulation? Y N

WOMEN ONLY:

_____Painful Menstruation
_____Excessive Flow
_____Cramps/Backache
_____Irregular
_____Abnormal Discharge
Passed Menopause? Y N
Birth Control? Y N
Prev. Miscarriages? Y N

Are you currently pregnant?
____ Yes Due Date: _________
____ No ____ Not Sure

List all surgeries: ____

____

What medications, even non-prescription, are you taking? ______________________

____

Is your visit due to an accident, injury, or trauma? Y N If so, was it: AUTO _______ WORK ______
Briefly Describe the events of the accident: ______________________________

____

Have you seen any other health care providers for this accident, injury, or trauma? Y N Who? ________
What treatment did you receive? ______________________________________

CHIROPRACTIC INSURANCE COVERAGE

Please call your insurer(s) prior to your appointment, and bring this sheet with you. It is required for your patient file.

Patient's Name______________________________ Date ____________________

Date of Birth _________________________ I.D # _____________________

Insurance Provider ____________________ Plan Number _______________

1. Do you have additional coverage through your spouse/partner?

   YES_______ NO________

   If so, please call both insurers, and provide the same information.

2. Does the policy cover chiropractic? YES_______ NO________
3. Does the policy cover x-rays? YES_______ NO________
4. Does the policy cover orthotics? YES_______ NO________
5. What are the coverage limits? (Number of visits, % coverage, $ coverage)

____

____

6. What is the coverage timeline / reset date? __________________________

Confirmation/Referral # ____

PLEASE NOTE:

WE DO NOT BILL YOUR INSURANCE DIRECTLY. HOWEVER, WE WILL PROVIDE YOU WITH A STATEMENT AT YOUR REQUEST TO CLAIM WITH YOUR INSURER.

Patient's Initials: ________

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chiropractic