Healing Arts
CHIROPRACTIC
HEALTH & WELLNESS CENTER

CONFIDENTAL PATIENT INFORMATION

This information is confidential. In order for us to understand your health problems properly, please complete this form.

Date: _____ Chart #: _____ SS#: _____

Name: _____ Home Phone #: _____
Cell Phone#: _____
Address: _____ City/Zip: _____

Date of Birth: _____ Marital Status: S M W D # Children: _____
Occupation: _____ Employer: _____
Address: _____ Office Phone #: _____
Email Address: _____
Emergency Contact: _____ Phone #: _____

Please Circle Your Symptoms (Circle all that currently apply):

Neck Pain	Upper Back Pain	Middle Back Pain	Low Back Pain
Shoulder Pain	Elbow Pain	Wrist Pain	Arm/Hand Pain or Numbness
Rib Cage Pain	Hip Pain	Knee Pain	Thigh/Leg Pain or Numbness
Foot/Ankle Pain	Chest Pain	Groin Pain	Headaches/Head Pain

Other: _____

DOCTORS CONSULTED FOR THIS CONDITION:

Hospital Name: _____ Date admitted: _____ Date Discharged: _____
Treatment: _____ Follow-up Instructions: _____

Dr. Name: _____ When Consulted: _____
Treatment Offered: _____ Results: _____

Present Family Doctor: _____ Town: _____ Last Physical: _____

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Chiropractic Physician | Certified Acupuncturist | Hypnotherapist | Shamanic Practitioner

FINANCIAL INFORMATION:

Health Insurance Company: _____ Policy #: _____
ID #: _____ Insured: _____

Secondary Health Insurance: _____ Policy #: _____
ID #: _____ Insured: _____

Attorney Name: _____ Phone #: _____
Address: _____ City, State, Zip: _____

HOW DID YOU HEAR ABOUT US?

_____

PAST MEDICAL HISTORY:

WHAT SURGERIES HAVE YOU HAD?
(Type/When/Doctor/Results)_____
_____
_____

LIST FORMER SERIOUS ACCIDENTS AND FALLS: (AUTO, WORK, HOME, LEISURE, SPORTS, OTHER)
(What/When/Symptoms/Treatment)_____
_____
_____

BROKEN BONES, DISLOCATIONS?
(When/How/Doctor/Results)_____
_____
_____

LIST MEDICATIONS AND/OR DIET SUPPLEMENTS YOU TAKE
(What/Frequency/Doctors/Side Effects/Remarks)_____
_____
_____

LIST ANY DISEASE OR ILLNESS WITH WHICH YOU HAVE BEEN DIAGNOSED
(Ex: Diabetes, Heart Disease, High Blood Pressure, Stroke, Asthma, Ulcers, Cancer, Arthritis, Depression)
_____
_____

WORK ACTIVITIES
Work Responsibilities – Lifting, bending, stooping, turning, twisting, carrying, walking, standing, sitting etc.
_____
_____

LEISURE ACTIVITIES
Sports and exercise type, frequency, length of time, etc. _____
_____
_____