

PATIENT INTRODUCTION CARD

Date: _____ Patient # _____
Patient Name: Last _____ First _____ Init. _____
Address: _____ City _____ State _____ Zip _____
Phone: (_____) _____ - _____ Birthdate: ____/____/____ Age _____
Sex: (M-male, F-female): _____ Marital Status: M S W D Patient Soc. Sec. #: _____
Patient Employed By: _____
Occupation: _____ Business Phone: (_____) _____ - _____
Insurance Coverage: _____ Spouses Birthdate: ____/____/____
Referred By: _____
Briefly Describe Chief Complaint (Symptoms) _____

How did it happen? _____
How would you rate your pain today (0 being no pain and 10 being the worst pain) _____
What have you done to try to help this problem so far? _____
Have you ever had same or similar complaint? Yes or No Explain _____
List all other health problems and symptoms you are having: _____

List all past surgeries _____
List all medications you are currently taking _____ for _____ for _____
_____ for _____ for _____ for _____

Have you been to a chiropractor before? Yes or No If Yes, for what? _____
FEMALES ONLY: To your knowledge are you pregnant? Yes or No (Circle One)
Are You Claiming Workmen's Compensation: YES _____ NO _____
Are You Claiming Auto Accident: YES _____ NO _____
Company or Insurance Name: _____

Address: _____ Phone #: (_____) _____ - _____
Attorney Name and Phone #: _____

- I Am Interested in Only Symptomatic Relief (Feel Better)
- I Am Interested in Symptomatic Relief, and Maximum Correction of My Problem
- I Am Interested in Symptomatic Relief, Maximum Correction and a Health Maintenance Plan

Do You Have Any Problems With The Following PRESENT PAST

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Bladder trouble |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hay fever | <input type="checkbox"/> T.B. | <input type="checkbox"/> Menstrual cramps, pain |
| <input type="checkbox"/> Arterio sclerosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tightness of throat | <input type="checkbox"/> Heart attacks | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Cervical arthritis | <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Chest and left arm pain | <input type="checkbox"/> Painful joints |
| <input type="checkbox"/> Recent severe neck strain | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Anemia | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Family history of strokes | <input type="checkbox"/> Twitching of face | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Dizziness or unsteadiness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervous stomach | <input type="checkbox"/> Slipped disc |
| <input type="checkbox"/> Fainting or lightheadedness | <input type="checkbox"/> Depression | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Ruptured disc |
| <input type="checkbox"/> Temporary loss of memory | <input type="checkbox"/> Head feels too heavy | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Previous disc surgery |
| <input type="checkbox"/> Numbness in face or arms | <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Nerves, nervousness | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Garbled speech | <input type="checkbox"/> Increased pain to cough, sneeze | <input type="checkbox"/> Inner tension | <input type="checkbox"/> Pinched nerves in back |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Grating in neck | <input type="checkbox"/> Irritability | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Recent severe, sudden head pain | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Numbness in legs |
| <input type="checkbox"/> Chronic headaches | <input type="checkbox"/> Tightness of shoulder muscles | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Pins and needles in arms, hands | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Intestinal gas | <input type="checkbox"/> Pains in legs & feet |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Kidney trouble | |

ANY FALLS, ACCIDENTS, INJURIES? YES NO
If yes, please explain _____

Please specify the Doctor of your choice: _____
PLEASE RETURN THIS FORM WITH YOUR INSURANCE CARD TO FRONT DESK