

## Natural Life Chiropractic Patient Information Form

### Patient Information:

Select File Then **Print** In your Browser Or [Click Here To Print This Page](#)

Thank you for choosing our practice for your chiropractic needs. **Please be sure to complete this form in full and use BLACK ink.** If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Date \_\_\_\_\_

First \_\_\_\_\_ MI \_\_\_\_\_

Last \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex: Female \_\_\_ Male \_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_ Home phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work phone # \_\_\_\_\_

We give reminder calls. Would you prefer to receive calls at: Home \_\_\_ Work \_\_\_ Cell \_\_\_

Are you: A Minor \_\_\_ | Married \_\_\_ | Divorced \_\_\_ | Partnered \_\_\_ | Widowed \_\_\_ | Single \_\_\_ | Separated \_\_\_

Your employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's or parent's name \_\_\_\_\_ Workplace \_\_\_\_\_ Work phone # \_\_\_\_\_

Who do we thank for referring you to us? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_

Phone # \_\_\_\_\_

### Responsible Party

Person responsible for this account? \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

### Symptoms

Reason for visit \_\_\_\_\_

When did you first notice the symptoms? \_\_\_\_\_

Is this condition getting progressively worse? Yes: \_\_\_ No: \_\_\_ The Same: \_\_\_

Where specifically is the problem(s) located \_\_\_\_\_

Which activities are difficult to perform? Sitting:\_\_\_ Standing: \_\_\_ Walking: \_\_\_ Bending:\_\_\_ Lying Down: \_\_\_\_\_

Type of pain: Sharp \_\_\_ Dull \_\_\_ Throbbing \_\_\_ Numbness \_\_\_ Aching \_\_\_ Shooting\_\_\_ Burning \_\_\_ Tingling  
\_\_\_\_\_

Cramps\_\_\_ Stiffness \_\_\_ Swelling \_\_\_ Other \_\_\_\_\_

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain Circle Choice): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? \_\_\_\_\_

What treatment have you already received for your condition? Other Chiropractor\_\_\_\_\_ Medication \_\_\_\_\_  
Surgery\_\_\_\_\_

Physical Therapy \_\_\_\_\_ Other\_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition:

\_\_\_\_\_

### **Health History**

Check only those conditions which are applicable:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Pinched Nerve        |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Pneumonia            |
| <input type="checkbox"/> Allergy Shots       | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Polio                |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Gout                | <input type="checkbox"/> Prostate Problems    |
| <input type="checkbox"/> Anorexia            | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Prosthesis           |
| <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Psychiatric Care     |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Herniated Disc      | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Bleeding Disorders  | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Scarlet Fever        |
| <input type="checkbox"/> Breast Lump         | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Suicide Attempt      |
| <input type="checkbox"/> Bulimia             | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Measles             | <input type="checkbox"/> Tonsillitis          |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Migraine Headaches  | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Miscarriage         | <input type="checkbox"/> Tumors, Growths      |
| <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Typhoid Fever        |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Vaginal Infections   |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Venereal Disease     |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Whooping Cough       |
| <input type="checkbox"/> Fractures           | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Other                |

Dates of last exams: \_\_\_\_\_

(Women) Are you pregnant? Yes \_\_\_ No \_\_\_ Nursing? Yes \_\_\_ No \_\_\_ Taking birth control pills? \_\_\_\_\_

List any types of surgeries which you have and the dates which they occurred:

\_\_\_\_\_  
\_\_\_\_\_

Please list all medications you are currently taking: \_\_\_\_\_

Allergies: \_\_\_\_\_

**Daily Habits**

What type of exercise do you perform on a daily basis ?( Circle Answer) None      Moderate      Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

\_\_\_\_\_

What vitamins do you currently take ? \_\_\_\_\_

What kind of other nutritional supplements do you take (if any):

\_\_\_\_\_

Do you smoke? \_\_\_ No \_\_\_ Yes      How much per day? \_\_\_\_\_

How much liquor do you consume on a weekly basis? \_\_\_\_\_

How much coffee or caffeinated beverages do you consume on a daily basis? \_\_\_\_\_

**Authorization**

I certify that I have read and understand the above information to the best of my knowledge The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X \_\_\_\_\_ Date \_\_\_\_\_

SIGNATURE OF PATIENT (or parent if a minor)