Confidential Patient Information

Name _____ Cell _____ Home Phone _____

Address _____ City _____ St. _____ Zip _____

Date of Birth _____ Martial Status (Circle one) M S D W Age _____

Social Security Number _____ - _____ - _____ E mail address _____

Occupation _____ Employer _____

Work Address _____ City, St. Zip _____

Spouse's Name _____ # of Children _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Who may we thank for referring you to our office? _____

Have you ever had chiropractic before? Yes ☐ No ☐ Date _____

Is this injury or illness relate to: Auto Accident ☐ Work Related ☐

Date: _____ Claim #: _____

Your Auto Insurance Co: _____ Phone: _____

Due to constant change in health insurance fees and coverage, our office does not accept insurance as payment for services rendered for our patients. All fees incurred are paid by the patient. If the patient has insurance that will reimburse them for their care, we will be happy to bill as a courtesy. All insurance reimbursements are sent directly to the patient.

All charges are due when services are rendered...

Method of payment ( ) Check ( ) Cash ( ) Credit Card

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care

Corrective Care differs from relief care in that it's goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective Care varies in length of time, but is more lasting.

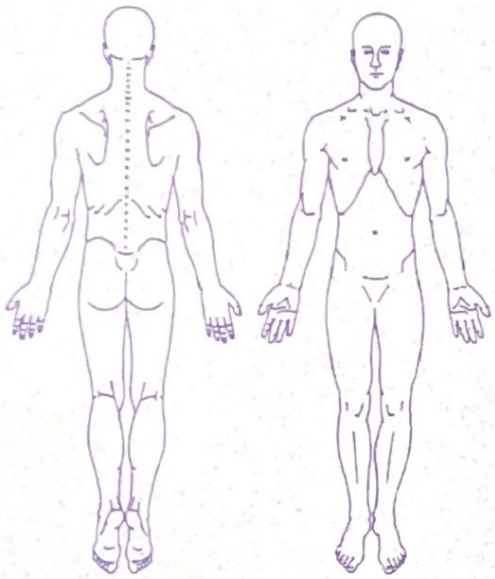
I authorize Baker Family Chiropractic to render necessary services to me and I am responsible for all charges incurred.

Patient Signature _____ Date _____

Guardian or spouse's authorizing care _____

Thank You For Allowing Us To Serve You!

PLEASE MARK AN X ON THE DIAGRAM
WHERE YOUR PROBLEMS ARE



What hurts and how long has it hurt?

_____

_____

_____

List your chief complaints in order of severity

1. _____
2. _____
3. _____

List other Chiropractic or Medical Doctors you have consulted for these conditions.

_____

_____

Check and or circle any of the following you have had in the last six months.

( ) Neck, mid, or low back pain
( ) Headaches / migraines
( ) Sinus congestion / allergies
( ) Vision Problems
( ) Earaches / ringing / buzzing / infections
( ) Dizziness / vertigo
( ) Heart / blood / pressure problems
( ) Poor circulation / ankle swelling
( ) Prostate / sexual dysfunction
( ) Menstrual cycle / sexual dysfunction
( ) Depression / nervousness / mood swings
( ) Numbness / shooting pain - location _____

( ) Stomach / indigestion problems
( ) Constipation / diarrhea
( ) Poor / excessive appetite
( ) Excessive thirst
( ) Painful / excessive urination
( ) Discolored urine
( ) Hemorrhoids
( ) Diabetes
( ) Cancer
( ) Bladder / liver / kidney problems
( ) Leg pain /. cramping

Are you pregnant? ( ) Yes ( ) No ( ) Not sure