

# MOST

CHIROPRACTIC CLINIC

## PATIENT INFORMATION

Today's Date: \_\_\_\_\_

Legal Name: \_\_\_\_\_

Nickname: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ SSN #: \_\_\_\_\_

Driver's License #: \_\_\_\_\_

Home Phone #: ( ) \_\_\_\_\_ Cell Phone#: ( ) \_\_\_\_\_

Work Phone #: ( ) \_\_\_\_\_ Preferred Contact # (circle one): **H C W**

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address (if known): \_\_\_\_\_

Marital Status (circle one): **Single Married Divorced Widowed Separated**

Spouse's Name (if applicable): \_\_\_\_\_ Birth date: \_\_\_\_\_

SSN #: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

You were referred to this office by (circle one):

**Patient Doctor Attorney Yellow Pages/Ad Other** \_\_\_\_\_

Are we treating other family members: \_\_\_\_\_

## INSURANCE INFORMATION

**Primary Insurance Company Name:** \_\_\_\_\_

Phone #: ( ) \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's Identification #: \_\_\_\_\_

Group/Policy #: \_\_\_\_\_

**Secondary Insurance Company Name:** \_\_\_\_\_

Phone #: ( ) \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's Identification #: \_\_\_\_\_

Group/Policy #: \_\_\_\_\_

\*Please bring a copy of all insurance cards to our office on your initial visit so that we may scan your card into our computer.

\*\*In automobile or workman's compensation cases, please bring all contact information-insurance co, address, telephone/fax number, insurance adjuster's name and number, policy number.

\*\*\*In auto injury cases, please bring copy of police report (and other person's information if they are at fault).

### **SYMPTOM INFORMATION (1 of 2)**

**Please fill out the following information so that we can have comprehensive data on your current condition.**

Are your symptoms the result of an accident? Yes No

If yes, what type? Auto Job Other: \_\_\_\_\_

What date did your symptoms appear? \_\_\_\_\_

Are your symptoms: Constant Frequent Intermittent Occasional

Where are you having symptoms:

Primary location \_\_\_\_\_

Secondary location \_\_\_\_\_

Additional location(s) \_\_\_\_\_

Are your symptoms radiating into your arms or legs? Yes No

Location: \_\_\_\_\_

Are your symptoms (circle all that apply):

Ache Burning Cramp Deep Dull Numbness Piercing Pins & Needles

Sharp Shooting Soreness Stabbing Spasm Tenderness Tightness

Tingling Throbbing Weakness

What **improves** your symptoms (circle all that apply):

Ice Heat Massage OTC Medication Muscle Relaxer/Pain Med Rest Physical

Activity Bending Sitting Standing Walking

Other \_\_\_\_\_

### **SYMPTOM INFORMATION (2 of 2)**

What **aggravates** your symptoms (circle all that apply):

Bending Coughing Driving Lifting Movement Physical Activity Rest

Sitting Sneezing Standing Twisting Walking

Other \_\_\_\_\_

Do symptoms affect (circle all that apply):

Sleep Daily Activities Work Activities Recreational Activities

Describe your job activities: \_\_\_\_\_

**Please rate your pain from 0 (no pain) to 10 (unbearable pain) for:**

Primary Symptoms \_\_\_\_\_ ; Secondary Symptoms \_\_\_\_\_ ; Third Symptoms \_\_\_\_\_ ;

Additional Symptoms:\_\_\_\_\_.

Please mark area(s) of injury/symptoms utilizing the diagrams below:

**Right Side**



**Front Side**



**Back Side**



**Left Side**



### **MEDICAL HISTORY**

Have you had these symptoms in the past? Yes No If Yes, When? \_\_\_\_\_

What treatment was performed? (circle all that apply):

Massage Chiropractic Medication Physical Therapy X-rays MRI

Other: \_\_\_\_\_

Present Weight: \_\_\_\_\_ lbs.; Height: \_\_\_\_\_ ft. \_\_\_\_\_ in.

Current Medication: \_\_\_\_\_

Hospitalizations/Surgeries: \_\_\_\_\_

Do you have a permanent disability rating? Yes No

Location \_\_\_\_\_; Rating \_\_\_\_\_%; When? \_\_\_\_\_

Important Medical Conditions:

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

I affirm that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in my medical status. I voluntarily consent to receive chiropractic care services that include diagnostic procedures, examination, and treatment. I authorize Most Chiropractic Clinic/Dr. Bridget Most to bill any charges incurred to my insurance company (if applicable) and assign benefits to be paid directly to Most Chiropractic Clinic/Dr. Bridget Most.

Signature of Patient/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_