Welcome to Denison Chiropractic Clinic

Please circle the type of care desired: Temporary Relief or Lasting Correction

Date:: _____ Name: First/Middle/Last: _____

Birth date: _____ Social Security Number: _____

Address: _____ City: _____ State/Zip: _____

Phone: _____ Circle if you are: Married Single Divorced Widow Separated

Work Phone: _____ Cell Phone: _____ Email Address: _____

Name of husband/wife: _____ Number of Children: _____

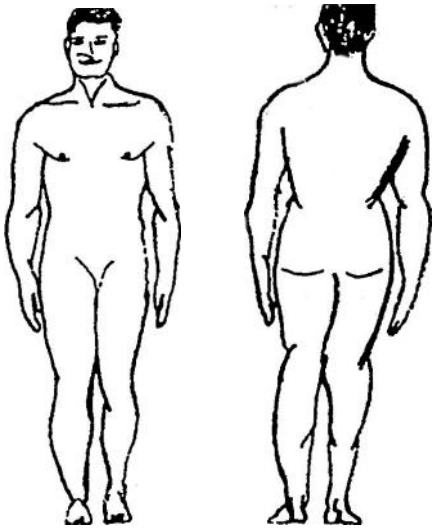
Where are you employed: _____ Where is spouse employed: _____

Who can we thank for your referral, to this office: _____

Circle who is responsible for your bill: self spouse employer Insurance.

Name of insurance company: _____

If you are in pain, please•mark the exact location of your pain on the diagram below.



Major Complaint
(Please describe your problem)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

How did this condition develop? (What caused it) _____

_____

When was the very first time you were aware of this problem? _____

Have you ever had this problem or similar before? If yes, please explain _____

_____

Please complete reverse side

Have you received treatment for this condition? If yes, where and when and what were your results? _____

_____

Please circle if this problem has been getting: better worse stay the same

Is there anything you do that makes your condition worse? _____

_____

Please circle if you have been in an automobile accident? Past year past 5 years over 5 years

Any accidents, falls, etc., that might have caused your problem? _____

_____

What surgery has been done? _____

Circle drugs you take now: pain killers muscle relaxers insulin ibuprofen birth control pills

other _____

Any Chiropractors consulted in the past? Name: _____

Patient's
Signature: _____ Date: _____

Complete only if yours is an accidental injury
(auto; workman's comp , personal injury)

Date of accident Hour: a.m. p.m. Location

Circle how accident occurred? Auto On the job Other _____

Circle if you reported injury to your foreman or employer? Yes No

Circle if they recommended care at this office? Yes No

Circle if they recommended care at this office? Yes No

Circle — If auto accident, Were you? Driver Passenger Pedestrian

Circle — If auto accident, Were you? Driver Passenger Pedestrian

Circle — If auto accident, Were you? Driver Passenger Pedestrian

If auto accident, were you struck from? Behind right side left side other _____

If auto accident, were you struck from? Behind right side left side other _____

Circle symptoms you have noticed since the accident:

Headache	dizziness	stomach upset	neck pain	numbness in toe
Fatigue	cold sweats	shortness of breath	neck stiffness	light bothers eyes
Face flushed	depression	sleeping problems	ears ring	loss of balance
Back pain	diarrhea	fainting spells	feet cold	head seems too heavy
Nervousness	loss of smell	tension	hands cold	pins & needles in arms
Irritability	fever	loss of memory	loss of taste	pins & needles in legs
Chest pain	constipation	buzzing in ears		numbness in fingers

Symptoms other than above? _____

Have you lost any days off? _____

Name of insurance company of person responsible for injuries? _____

Have you been contacted by an insurance adjuster of company representing the claim? Yes No

Do you have an attorney who is advising you in this case? Yes No

Attorney Name/address/phone: _____