Terry Family Chiropractic

Dan Terry, D.C.

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PATIENT INFORMATION

Date:_____ Patient Name: (Last, First, Initial): _____
Mailing Address:_____
(City) (State) (Zip Code)

Date of Birth:_____ Patient SS#:_____ Height:_____ Weight:_____
Gender: ❑Male ❑Female ❑Single ❑Married ❑Widowed ❑Divorced
Primary Care Doctor:_____ Employer:_____ Occupation:_____
Spouse's Name:_____ Spouse's Employer:_____ Number of Children:_____
Whom may we thank for referring you? _____

PHONE NUMBERS
Home: _____ Work:_____ Cell:_____
Best time and place to reach you? _____

CONTACT IN CASE OF EMERGENCY
Name:_____ Relation:_____
Home #:_____Work #:_____

Patient Appointment Reminders by ❑ Text, ❑Phone call, or ❑ Email _____

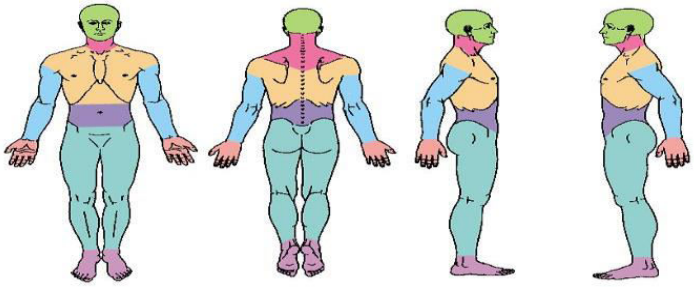
PATIENT CONDITION

Reason for Visit:_____ When did symptoms appear?_____
Is this condition getting progressively worse? ❑Yes ❑No Rate the severity of pain on a scale of 1 (least pain) to 10:___
How often do you have this pain?_____ Is it constant or intermittent?_____
Type of Pain: ❑Sharp ❑Dull ❑Throbbing ❑Numbness ❑Aching ❑Shooting ❑Burning ❑Tingling ❑Cramps ❑Stiffness ❑Swelling ❑Other_____ **Does the pain interfere with:** ❑Work ❑Sleep ❑Daily Routines ❑Recreation
Activities that are painful to perform: ❑Sitting ❑Standing ❑Bending ❑Lying down

ACCIDENT INFORMATION

Is this condition due to an accident? ❑Yes ❑No Date of accident:_____ Date of onset of pain:_____
Type of Accident: ❑Auto ❑Work ❑Other_____ to who was the accident reported? ❑Auto Insurance ❑Employer ❑L&I ❑Other_____

Please mark an X on the picture where you have pain, Numbness or tingling.



INSURANCE INFORMATION

Person responsible for account:_____
Relationship to Patient:_____
Insurance Company:_____
ID#:_____ Group #:_____
Secondary Coverage? ❑Yes ❑NO
Insurance Co.:_____
ID#:_____ Group #:_____

INSURANCE INFORMATION

I understand, certify that I (or my dependant) have insurance coverage with _____ and assign directly to Dr. Terry all insurance benefits, if any, otherwise payable to me for services redeemed. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Dr. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

_____

Responsible Party's Signature Date

HEALTH HISTORY

What treatment have you already received for your condition? ❑Medication ❑Surgery
❑Physical Therapy ❑Chiropractic ❑None ❑Other _____
Name the above Doctor, Therapist or facility where you treated for your condition:
_____

Date of Last: Physical Exam_____ Spinal x-ray _____ Blood Test _____
Spinal Exam_____ Chest x-ray_____ Urine Test_____
MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" to any you are currently having:

MusculoSkeletal

Low Back Pain	❑Y❑N
Neck Pain	❑Y❑N
Arm Pain	❑Y❑N
Joint Pain	❑Y❑N
Joint Stiffness	❑Y❑N
Walking Problems	❑Y❑N
Difficulty Chewing	❑Y❑N
Clicking Jaw	❑Y❑N

CardioVascular

Chest Pain	❑Y❑N
Short Breath	❑Y❑N
Blood Pressure	❑Y❑N
Heart Problems	❑Y❑N
Lung Problems/ Congestion	❑Y❑N
Varicose Veins	❑Y❑N

Ear, Nose, Throat

Vision Problems	❑Y❑N
Ear Aches	❑Y❑N
Hearing Difficulty	❑Y❑N
Stuffed Nose	❑Y❑N

Nervous System

Nervousness	❑Y❑N
Numbness	❑Y❑N
Dizziness	❑Y❑N
Forgetfullness/ Confusion/ Depression	❑Y❑N
Fainting	❑Y❑N
Convulsions	❑Y❑N
Cold/tingling Extremities	❑Y❑N

Male/Female

Menstrual Irreg.	❑Y❑N
Cramps	❑Y❑N

Male/Female Continued

Vaginal Pain	❑Y❑N
Breast Pain	❑Y❑N
Prostate	❑Y❑N
Other problems	❑Y❑N

Genital-Urinary

Bladder Trouble	❑Y❑N
Painful/excessive Urination	❑Y❑N

Gastro-Intestinal

Poor excessive Appetite	❑Y❑N
Frequent Nausea	❑Y❑N
Vomiting	❑Y❑N
Diarrhea	❑Y❑N
Constipation	❑Y❑N
Hemorrhoids	❑Y❑N
Liver problems	❑Y❑N
Gall Bladder prob	❑Y❑N

Gastro-Intestinal Cont.

Weight Trouble	❑Y❑N
Abdominal Cramps	❑Y❑N
Gas/Bloating After meals	❑Y❑N
Heartburn	❑Y❑N

General

Fatigue	❑Y❑N
Allergies	❑Y❑N
Loss of Sleep	❑Y❑N
Fever	❑Y❑N
Headaches	❑Y❑N

Other_____
_____
_____
_____

Exercise
❑None
❑Moderate
❑Daily
❑Heavy

Work Activity
❑Sitting
❑Standing
❑Light labor
❑Heavy Labor

Habits
❑Smoking
❑Alcohol
❑Coffee/Caffeine Drinks
❑High Stress Level

Are you pregnant? ❑Yes ❑No Due Date:_____

Injuries/Surgeries you have had	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

CAR ACCIDENTS_____

Medications	**Allergies**	**Vitamins/Herbs/Minerals**
_____	_____	_____
_____	_____	_____
_____	_____	_____