CRANFORD CHIROPRACTIC

Patient Information

Name
_____
Date_____

Address
_____
City_____State_____
Zip_____

Phone _____
Date of Birth _____Age_____
Occupation
_____

Have you ever received Chiropractic Care?
Yes__ No__ If yes, when?
_____

_____

_____

_____

INSURANCE

Company_____
Effective date_____
Insured #_____
Group #_____
Plan Name_____

Accident

Is this injury due to an accident?

_____

_____

_____

_____

Patient Condition

Primary reasons for seeking chiropractic care:

_____

What was the initial cause of this complaint?

_____

Are you presently under a doctor's care for this complaint? Y/N
Doctors name:_____

Please circle the Quality of the complaint/pain:
dull aching sharp shooting burning throbbing deep nagging
other _____
Does this complaint/pain radiate or travel to other areas of your body? Y/N
Where? _____
Do you have any numbness or tingling in your body? Y/N
Where? _____

Grade Intensity/Severity (0 No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (10 Worst possible pain/complaint imaginable)

How frequent is complaint present. How long does it last?
_____
Does anything aggravate the complaint?
_____
Does anything make the complaint better?
_____
Does this complaint interfere with: work, home life, activities or sleep? Y/N
_____
Previous interventions: treatments, medications, surgery, or care you've sought for your complaint
_____

Past Health History

Previous illnesses you've had in your life:
_____

Have you ever broken any bones? Which?
_____
AllergiesMedications:_____

Condition/s you are taking medications for:
_____

Surgeries and dates:
_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me/child with chiropractic care, in accordance with this state's statutes. Parent or Guardian

Signature _____

Date _____