

# WARNINGER CHIROPRACTIC CLINIC

**CONFIDENTIAL PATIENT INFORMATION (BOTH SIDES)**

DATE: \_\_\_\_\_

Name \_\_\_\_\_ Social Security No. \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex: M F Marital Status: M S W D How Many Children? \_\_\_\_\_

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

Address \_\_\_\_\_ Office Phone \_\_\_\_\_

Insured's Name (If patient is dependent) \_\_\_\_\_ Social Security \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Patient's Nearest Relative \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Referred By (Who Told You About Us) \_\_\_\_\_

Is condition due to injury or sickness arising out of  Your Employment  Auto Accident  Other Accident \_\_\_\_\_

Date Symptoms Appeared \_\_\_\_\_ Patient ever had same or similar condition: Yes \_\_\_ No \_\_\_ If yes, when and describe \_\_\_\_\_

Have you lost any days from work? Yes \_\_\_ No \_\_\_ How Many? \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

What operations/serious illnesses have you had? \_\_\_\_\_

**ARE YOU NOW HAVING OR HAVE YOU HAD ANY OF THESE CONDITIONS: (PLEASE CHECK)**

<b>Now Past</b>	<b>Now Past</b>	<b>Now Past</b>	<b>Now Past</b>
<input type="checkbox"/> Allergies	<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Kidney Infection/Stone	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Colon Trouble	<input type="checkbox"/> Prostrate Trouble	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Difficult Digestion	<input type="checkbox"/> Cramps or Backache	<input type="checkbox"/> Pain Over Heart
<input type="checkbox"/> Headache	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Excessive Menstrual Flow	<input type="checkbox"/> Poor Circulation
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Rapid Heart Beat
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Deafness	<input type="checkbox"/> Irregular Cycle	<input type="checkbox"/> Slow Heart Beat
<input type="checkbox"/> Depression	<input type="checkbox"/> Ear Noises	<input type="checkbox"/> Lumps in Breast	<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Enlarged Thyroid	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Foot Trouble	<input type="checkbox"/> Failing Vision	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Difficult Breathing
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Itching	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Neck Pain/Stiffness	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Cancer
<input type="checkbox"/> Sciatica	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Spinal Curvatures	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Sinus Infection	<input type="checkbox"/> HIV/AIDS

**Social:** Heavy Moderate Light None

Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Tingling or Numbness In:(Circle)**

Shoulders	R / L	Hips	R / L
Arms	R / L	Legs	R / L
Elbows	R / L	Knees	R / L
Hands	R / L	Feet	R / L

Family History	Living	Age or Age of Death	Arthritis	Cancer	Diabetes	Heart	High Blood Pressure	Low Blood Pressure	High Cholesterol	Stroke	Other, Description
Father											
Father's Parents											
Mother											
Mother's Parents											
Your Siblings											
Your Children											

\_\_\_\_\_  
Doctors Signature

**PLEASE PRINT**

Purpose of this appointment (Major Complaint) \_\_\_\_\_

What activities aggravate (flareup) your condition? \_\_\_\_\_

What are you doing to help your condition? (heat, ice, medications, etc.) \_\_\_\_\_

Is this condition getting progressively worse? Yes \_\_\_ No \_\_\_ Constant \_\_\_ Comes and goes \_\_\_\_\_

Is this condition interfering with your: Work \_\_\_ Sleep \_\_\_ Daily Routine \_\_\_ Other \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

What do you believe is wrong with you? \_\_\_\_\_

Other Doctors seen for this condition \_\_\_\_\_

Have you been treated for any health conditions by a physician in the last year? Yes \_\_\_ No \_\_\_

Describe \_\_\_\_\_

What medications or drugs are you taking? \_\_\_\_\_

Are you dieting? Yes \_\_\_ No \_\_\_ If so, describe \_\_\_\_\_

List nutritional supplements you take \_\_\_\_\_

Do you have sufficient energy for normal activities? Yes \_\_\_ No \_\_\_ If no, describe \_\_\_\_\_

Do you sleep well? Yes \_\_\_ No \_\_\_ If no, describe \_\_\_\_\_

Are you wearing heel lifts? Yes \_\_\_ No \_\_\_ Arch supports? Yes \_\_\_ No \_\_\_

Are you pregnant? Yes \_\_\_ No \_\_\_ Date of last menstrual cycle \_\_\_\_\_

Remarks and additional information \_\_\_\_\_

**PAYMENT IS EXPECTED AT TIME OF VISIT**

Name of person responsible for payment \_\_\_\_\_

Are you insured? Yes \_\_\_ No \_\_\_ Company \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Warninger Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the Warninger Chiropractic Clinic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

**PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE**

**DATE**

\_\_\_\_\_  
Doctors Signature