Leander Chiropractic Center

Patient Information

Today's Date:_____/_____/_____
Name____
Address____
____
____
City State Zip
Home Telephone ____________________________________
Cell/Work Phone____________________________________
Best time and place to reach you____________________
Patient's Birthday__________________________________
Employer____
Work Telephone_____________________________________
Occupation____

(If patient is a minor, please write in parent's information below:)
Spouse's Name_____________________________________
Spouse's Birthday__________________________________
Occupation____
Spouse's Employer__________________________________
Whom may we thank for referring you to our office?

Insurance

Name of Insured___________________________________
Relationship to Patient_____________________________
Insurance Co.______________________________________
ID#____
Date of Birth_______________________________________
Group#____
Is patient covered by additional insurance? Y N

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent)have insurance coverage and assign directly to Dr. Blatchley D.C. all insurance benefits, if any, for service rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

____
Relationship Date

Patient's Condition

Reason for visit ____
How long ago did your symptoms first appear?_________________________________
What were you doing when they appeared?____________________________________
Is this condition getting progressively worse? Yes No
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)___________
Is it constant or does it come and go?

Place an X next to the left of the symptoms that you have had in the past 3 months:

	Symptom		Symptom
	Headaches		Numbness in legs Rt. Lt.
	Neck Pain		Numbness in Arms Rt. Lt.
	Mid Back Pain		Numbness in Hands Rt. Lt.
	Low-back Pain		Difficulty Sleeping
	Dizziness		Pins & Needles in Arms Rt. Lt.
	Chest/Sternum Pn.		Pins & Needles in Legs Rt. Lt.
	Nausea		Leg Pain Rt. Lt.
	Nervousness		Shoulder Pain Rt. Lt.
	Fatigue		Foot/Ankle Pain Rt. Lt.
	Loss of Balance		General Tension
	Jaw Pain		Depression
	Buzzing in Ears		Stomach Upset
	Loss of Memory		Shortness of Breath

Write in any other:

Color the chart where your symptoms are bothering you the most.

Back: L R
Front: R L

Past Health History

What treatment have you already received for your condition? Circle all that apply.

Medications Surgery Physical Therapy Chiropractic Services None Other__________________________

In case we need to refer you in the future, please write the name of your medical doctor_________________________

Place an X in the box to the left of each of the conditions listed below that you have been diagnosed with in the past:

	Allergies		Heart Disease		Osteoporosis
	Appendicitis		Hemophilia		Pacemaker
	Arthritis		Bulging/Herniated Disk		Parkinson's Disease
	Asthma		Hernia		Pinched Nerve
	Bleeding Disorders, Poor Clotting		Hypertension		PMS
	Cancer		Hypotension		Polio
	Diabetes		Kidney Disease		Prosthesis:
	Epilepsy		Migraine Headaches		Rheumatoid Arthritis
	Heartburn		Multiple Sclerosis		Stroke

Is there a family history of any of the following: Write in their relationship to you, ex: mom, dad etc.

Neck Pain	Nervousness	Numbness in legs
Mid-back Pain	Fatigue	Numbness in Arms
Low-back Pain	Loss of Balance	Numbness in Hands
Headaches	Jaw Pain	Difficulty Sleeping
Dizziness	Buzzing in Ears	Pins & Needles in Arms
Chest/Sternum Pn.	General Tension	Pins & Needles in Legs
Shoulder Pain	Foot/Ankle Pain	Leg Pain

Are you Pregnant? No Yes Due Date__________________________

Please list any of the following:	Description	Dates
Falls		
Head Injuries		
Auto Accidents		
Broken Bones		
Dislocations		
Surgeries		
Surgeries		
Surgeries		

List any condition in which you take medications (please don't list the drugs because they can become numerous):

____

Place an X to the left of any that apply to you.

Exercise		Work Activity		Sleeping Position		Nutrition	
	None		Sitting longer than 20 minutes		Back		Vitamins
	Moderate		Standing for longer than 1 hour		Sides		Herbs
	Heavy		Light Labor		Stomach		Minerals
			Heavy Labor		All Three		None