808 S. Bailey St., STE 103
Palmer AK 99645
907-707-1380

Confidential Patient Information

Date: _____

OFFICE USE ONLY PATIENT NAME:

Patient Name: _____ Date of Birth: _____

Mailing Address: _____ Chief Complaint: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

SS# _____ Email: _____

Address of Insured (if different than above): _____

Are your present symptoms or condition related to or the result of an auto collision, work related injury or other personal injury? (Someone else may be responsible for payment) ___ Yes ___No

Insurance Company: _____ Insurance Phone #: _____

ID #: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holder's Employer: _____

Family Physician:_____

May we send your health information to this provider? Y/N

Emergency Contact (name and phone): _____

Have you ever been under Chiropractic care? Y/N If so, who? _____

Have you had any SPINAL x-rays/ MRIs/ CTs taken in the last year? Y / N If so, where? _____

Surgeries and when you received them: _____

Serious illnesses and dates: _____

Infectious diseases and dates: _____

Do you have a pacemaker? Y / N Have you had a hip or knee replacement? Y / N when? _____

What medications or drugs are you taking? (Check all that apply)

__ Pain Killers __ Insulin __ Cholesterol meds __ Blood Pressure meds __ Muscle Relaxers __ Birth Control

__ Other: _____

What is your goal in our office? _____

Were you referred to our office by anyone? _____

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Family Chiropractic

PAST FAMILY HEALTH HISTORY

Patient name:_____

Have you or any blood relative had any of the following:

Condition/Problem	Relative/Self	Age
☐ Cancer		
☐ Hypertension		
☐ Diabetes		
☐ Mental Health		
☐ Heart Attack		
☐ Stroke		
☐ High Cholesterol		
☐ Autoimmune Disease		
☐ Factures		
☐ Osteoporosis		
☐ None of the above		

Other Major Medical Issues: _____

_____

_____

As a new patient to our clinic, would you appreciate a call to follow up on your care or answer any questions you may have?_____

_____

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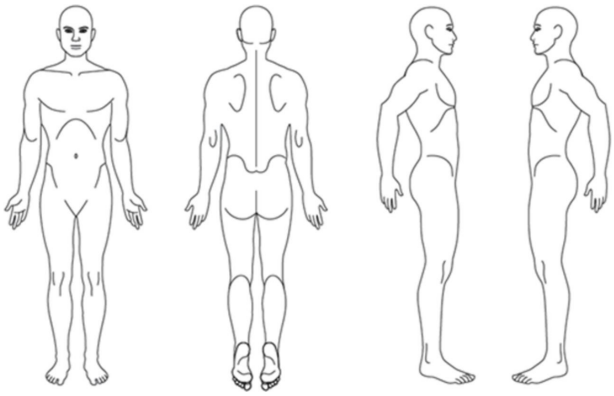
CASE HISTORY



Please mark figures where you experience pain

Patient name:_____

1. Circle the severity of pain (0= no pain, 10= very severe) and the frequency of pain (% of the week you experience pain).

Condition/Problem	Severity (Minimal … Severe)	Occasional … Consistent
a	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

2. Symptoms are worse in the (circle all that apply): morning / afternoon / night / increase during the day / same all day / decrease

3. Symptom (a.) is: sharp / dull / burning / aching / throbbing / numbness / tingling / pins & needles

4. Symptom (b.) is: sharp / dull / burning / aching / throbbing / numbness / tingling / pins & needles

5. When did your symptoms begin? _____

6. How did your symptoms begin? _____

7. Have you experienced this before? _____

8. Do your symptoms radiate? Y / N if Yes, how and where?_____

9. Since your symptoms began, has your condition: ___improved ___ gotten worse ___stayed the same

10. What makes your symptoms worse? (Circle all that apply)

bending / lying down / walking / standing / sitting / twisting / lifting / sleeping / moving

11. Is there anything that relieves the symptoms? _____

12. Is there anything you tried for relief that didn't work? _____

13. Are these symptoms interfering with ___ work ___ sleep ___ daily routine ___ recreation

14. Is this a problem you've been treated for before? Y /N How long ago? _____

15. What treatment did you receive? _____

16. Results of previous treatment? ___ Good ___ Poor Comments: _____

17. List any other major injuries you have has other that those mentioned: _____

_____

18. Musculoskeletal problems? Y / N Neurological Problems? Y /N

I certify that the above information is accurate to the best of my knowledge.

Patient/ Guardian Signature :_____ Date:_____