MAIN STREET CHIROPRACTIC

520 1st Ave SW, Largo FL 33770 (727) 518-1967

Patient Information & History

Date:_____

1 PATIENT INFORMATION

Name: _____

(First) (Initial) (Last) (Name called by)

Address: _____

City, State, _____ Zip: _____

Birthday: _____ Age: ____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____

Employer: _____

Referred to us by: _____

Parents Name(if a minor):_____

Spouse's Name: _____

# of Children: __Name(s)_____

2 INSURANCE

Who is responsible for this account?_____

Relationship to patient_____

Insurance company_____

Insurance ID number_____

Group / Claim number_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Insurance company_____

Subscriber # and name_____

Birthdate_____Group #_____

Please present insurance card(s) so we can put a copy in your file.

3 ACCIDENT INFORMATION

Is your condition due to an accident? ☐ No ☐ Yes Date: _____

Type of accident? ☐ Automobile ☐ Work ☐ Home ☐ Other

To whom have you reported the accident?

Insurance ☐ Worker's Comp ☐ Employer ☐ Other_____

Attorney Name (If applicable)_____

4 CONTACT INFORMATION

Home phone_____

Cell phone_____

Work Phone_____Ext_____

Email_____

Best way to reach you ☐ Home ☐ Cell ☐ Work ☐ Email

IN CASE OF EMERGENCY, CONTACT

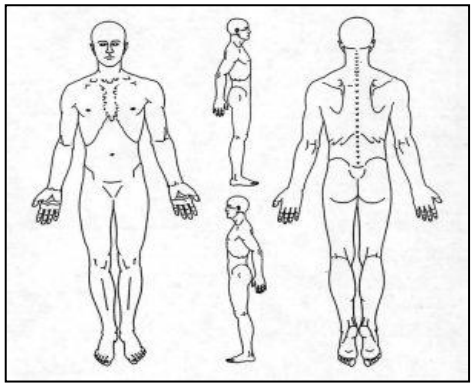
Name_____Relationship_____

Home Phone_____Cell_____

5 PATIENT CONDITION

What is your major symptom/problem? _____

Please mark where it hurts



Circle below the severity of your pain on a scale of 0 to 10:

(No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe pain)

What makes your condition better? _____

What makes your condition worse? _____

When/ how did your symptoms begin? _____(date)_____

Have you had this problem before? Yes ☐ No ☐

Is your condition getting progressively worse? Yes ☐ No ☐

Is this problem: ☐ constant ☐ comes and goes

How does it Feel? ☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Stiff

☐ Electric ☐ Fiery ☐ Shooting ☐ Deep ☐ Superficial Other _____ ☐ Radiating to _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities/movements that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Lifting ☐ Reading ☐ Getting Up

- Please continue on the back -

6 HEALTH HISTORY

What other treatments/ diagnostics have you had for this condition?

☐ Chiropractic ☐ Orthopedic ☐ Neurologist ☐ Physical Therapy ☐ Medication ☐ Surgery ☐ X-Ray ☐ MRI ☐ CTscan

Name of other doctors who have treated you for this condition_____

Name_____Address_____ Phone_____ Date Seen_____

Name_____Address_____ Phone_____ Date Seen_____

Describe the other doctor's treatment for your condition_____

Previous Chiropractic care? ☐ No ☐ Yes Date_____ ☐ Local ☐ Out of state _____

List any Medications you are taking_____

Vitamins / Herbs / Minerals _____

Females: Are you Pregnant ☐ Yes ☐ No Beginning of last menstrual cycle_____

Check any of the following conditions you have had or currently have:

Had	Have		Had	Have		Had	Have	
☐	☐	AIDS/HIV	☐	☐	Herniated disk	☐	☐	Polio
☐	☐	Allergies	☐	☐	Kidney Problems	☐	☐	Venereal Disease
☐	☐	Anemia	☐	☐	Low Blood Pressure	☐	☐	Epilepsy
☐	☐	Arthritis	☐	☐	Mental/Emotional Difficulty	☐	☐	Vertigo/Dizziness
☐	☐	Asthma	☐	☐	Multiple Sclerosis			
☐	☐	Bone Fracture	☐	☐	Pacemaker			
☐	☐	Cancer	☐	☐	Prostate Trouble			
☐	☐	Cirrhosis/Hepatitis	☐	☐	Rheumatic Arthritis			
☐	☐	Diabetes	☐	☐	Scoliosis			
☐	☐	Dislocated Joints	☐	☐	Sinus Problems			
☐	☐	Diverticulitis	☐	☐	Spinal Disc Disease			
☐	☐	Hay Fever	☐	☐	Thyroid Problems			
☐	☐	Heart Disease	☐	☐	Tuberculosis			
☐	☐	High blood pressure	☐	☐	Ulcer			

Family History of:

☐ Allergies
☐ Arthritis
☐ Cancer
☐ Cirrhosis/Hepatitis
☐ Diabetes
☐ Heart Disease
☐ Spinal Disc Disease
Other_____

STRESSORS

☐ Alcohol Drinks/Week _____
☐ Smoking Packs/Day _____
☐ Coffee/ Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

EXERCISE

☐ None
☐ Light
☐ Moderate
☐ Strenuous Hours/Week _____

Have you had any:	**Description**	**Date**
Automobile accidents		
Surgeries		
Broken bones		
Falls/Head injuries		

7 AUTHORIZATION – NOTICE OF PRIVACY PRACTICES

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Main Street Chiropractic / Woody Brown D.C., P.A. to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be scanned into my patient chart.

_____ _____ _____

Signature Date Parent (if patient is a minor)