Patient Information Form

First Name: _____ MI:_____ Last Name: _____

Address: _____ City:_____ State: _____ Zip: _____

Phone: _____ Email: _____@_____

Date of Birth: _____ Sex: Male_____ Female_____ SSN: _____

Marital Status (circle one): Single Married Divorced Widowed

Occupation: _____ Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Updated Patient Information

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ I do not wish to provide this information
☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or other Pacific Islander
☐ Other _____

Ethnicity: ☐ I do not wish to provide this information
☐ Hispanic or Latino
☐ Non-Hispanic or Non-Latino
☐ Other _____

Smoking Status: ☐ Current every day smoker
☐ Current some day smoker
☐ Former smoker
☐ Never smoked

Do you have any medication allergies? ☐ No known medication allergies
☐ Yes. What? _____

Are you currently taking any medications? ☐ Not currently prescribed any medications
☐ Yes. What? _____

How did you hear about our office?

☐ **Internet** ☐ **Newspaper** ☐ **Personal Referral:** Whom may we thank? _____

☐ **Work Injury** ☐ **Auto Accident** ☐ **Other Accident**

I understand that (regardless of my insurance status) I am ultimately responsible for this balance on my account for all professional services rendered. **I understand that I am responsible to determine my insurance benefits.** I have read all the information on this sheet and have completed the above answers to the best of my ability. I certify this information is true and correct to the best of my knowledge. **I will notify you of any changes in my health status, the above information, and any changes in my insurance status.**

_____ _____
Signature Date

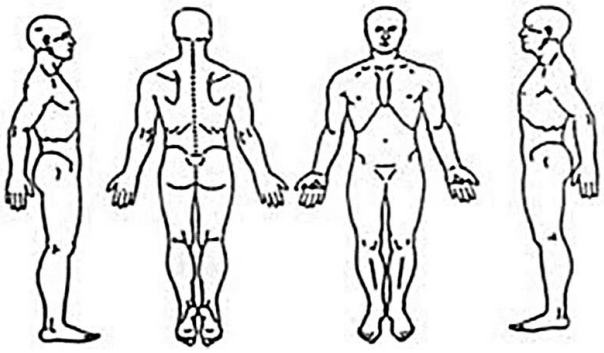
If Patient is a minor
Parents/Guardian Name: _____

_____ _____
Parents/Guardian Signature if minor Date

OVER →

What brings you into the office today? _____

Draw on the diagram below indicating where you are having pain.



When did it start? _____

How did it happen? _____

This complaint came on: ☐ Gradually ☐ Immediately
This complain is: ☐ Improving ☐ Staying the same ☐ Getting worse
The intensity of this complaint is: ☐ Minimal ☐ Slight ☐ Moderate ☐ Severe
The frequency of this complaint is: ☐ Occasional ☐ Frequent ☐ Constant
The pain is: ☐ Dull ☐ Sharp ☐ Aching ☐ Shooting ☐ Spasm ☐ Throbbing ☐ Burning ☐ Tingling

Have you seen another doctor for this problem? ____ Yes _____ No Whom? _____

Have you had any diagnosis tests (x-ray, lab, MRI, etc.) for this condition? _____

_____

Please check the appropriate box for all of the following items and please explain as clearly as possible

Yes	No		Yes	No	
☐	☐	Heart Attack/Stroke	☐	☐	Sinus Problems
☐	☐	Congenital Heart Defect	☐	☐	Difficulty Breathing
☐	☐	Alcohol/Drug Abuse	☐	☐	Artificial Bones/Joints
☐	☐	HIV +/ AIDS	☐	☐	Heart Murmur
☐	☐	Frequent Neck Pain	☐	☐	Hepatitis
☐	☐	High/Low Blood Pressure	☐	☐	Cancer
☐	☐	Severe/Frequent Headaches	☐	☐	Anemia
☐	☐	Fainting/Seizures/Epilepsy	☐	☐	Rheumatic Fever
☐	☐	Diabetes/Tuberculosis	☐	☐	Ulcers/Colitis
☐	☐	Lower Back Problems	☐	☐	Diabetes
☐	☐	Heart Surgery/Pacemaker	☐	☐	Asthma
☐	☐	Mitral Valve Prolapse	☐	☐	Chemotherapy
☐	☐	Venereal Disease	☐	☐	Arthritis
☐	☐	Shingles	☐	☐	Psychiatric Problems
☐	☐	Emphysema/Glaucoma	☐	☐	Kidney Problems

OFFICE USE ONLY—PLEASE DO NOT FILL OUT

Age_____ BP: _____/_____ Height: _____ Weight: _____

The following are activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?	Yes, limited a lot	Yes, limited a little	No, not limited
Vigorous activities, such as running, lifting heavy objects, participating in sports			
Moderate activities, such as moving a table, pushing a vacuum, bowling, or golfing			
Lifting or carrying groceries			
Climbing several flights of stairs			
Climbing one flight of stairs			
Bending, kneeling, or stooping			
Walking more than a mile			
Walking more than several blocks			
Walking one block			
Bathing or dressing yourself			

	Level of Pain									
Overall Condition	1	2	3	4	5	6	7	8	9	10
Headache	1	2	3	4	5	6	7	8	9	10
TMJ	1	2	3	4	5	6	7	8	9	10
Chest	1	2	3	4	5	6	7	8	9	10
Abdomen	1	2	3	4	5	6	7	8	9	10
Neck	1	2	3	4	5	6	7	8	9	10
Midback	1	2	3	4	5	6	7	8	9	10
Lowback	1	2	3	4	5	6	7	8	9	10

Consent for Treatment

Assignment & Release *- By signing below, I authorize Arlington Chiropractic & Acupuncture to release medical records required as deemed necessary. I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for payment at time of service. I understand that this office does not accept Medicaid. I understand that this office does submit insurance and Medicare claims. By signing below, I give my consent for chiropractic, massage therapy and/or acupuncture examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient. As with any healthcare procedure, there are certain complications which may arise during chiropractic and acupuncture therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, artery disruption, and bleeding. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.*

_____ _____

Patient/Parent/Guardian Signature Date