

CONFIDENTIAL PATIENT INFORMATION

Edinboro Family Chiropractic
12650 Edinboro Road
Edinboro, PA 16412

Name _____ DOB _____ Sex: Male, Female, Other
Address _____ City _____
State _____ Zip _____
SSN: _____ - _____ - _____ Phone: _____ Email: _____
Do you wish to have your billing statements emailed to you? Y / N

Do you have an Advanced Health Care Directive (Living will/ DNR)? Y / N
Marital Status: Single- Married- Widowed- Divorced-Separated- Partnered
Ethnicity: African American- Caucasian- Hispanic- Not Hispanic- Other _____
Sexual Orientation: Heterosexual / Homosexual /Bisexual / Chose not to disclose **Student?:** Y/N
Do you have Health Insurance? Y/N Name of insurance: _____
Who is financially responsible for this bill? _____
Do you have AFLAC? Y/N
Will you want a claim form to submit to AFLAC? Y/N (\$5.00 fee applies)

Employer _____ Occupation _____ Employer Phone _____

Emergency Contact _____ Relationship _____ Phone: _____

Where did you hear about us?
Phone book/ Internet /Friend/ Family /Health Fair /Billboard/ Poster /Lecture /Other _____
If Friend/ Family, please give name _____
Do we have your permission to send a thank you letter? Y/N

HISTORY OF INJURY

Describe your major complaint _____
Date of Onset _____
Is it work or auto related? Y/N
Have you seen a Physician for the present complaint? YES/NO Who/ When _____
Have you had any X-rays/ MRI/ CT Scan taken? YES/ NO Where and When _____
Please rate the severity of your problem- Mild- Moderate Severe

PAST MEDICAL HISTORY

Who is your PCP _____
What conditions are you currently being treated for _____
Previous Operations _____ Serious Illnesses _____
Hospitalizations _____ When/ Where _____
List any medications and the condition you are being treated for _____

FAMILY HISTORY

Please abbreviate relation- M=Mother, F=Father, S=Sister, B=Brother, Grand(parent)=G, Relation=R

Osteoporosis	Heart Problems	Cancer
High Blood Pressure	Stroke	Unknown
Bleeding Disorders	Genetic Disorders	Other
Diabetes	Heart Attack	

Do you have any sensitivities or drug allergies? _____

Date of last Physical Exam? _____ Height _____ Weight _____

REVIEW OF SYSTEMS (Circle any of the symptoms you are **CURRENTLY** experiencing.)

Chest Pain	Tingling	Prolonged Bleeding	Spasms/ Cramps
Dizziness	Rash	Numbness	Poor Balance
Excessive Fatigue	weakness	Headaches	Tremors
Lightheaded	Easy bruising	Visual Disturbances	Sinus Trouble
Fever	Nervousness	Abdominal Pain	Night sweats
Seizure	Insomnia	Weight change	

Have you ever had Chiropractic Care? Y/N Who _____ When _____

Have you ever had Massage Therapy? Y/N

Have you ever had Physical Therapy? Y/N

SOCIAL HISTORY

Are you a current smoker? Y/N How long have you smoked _____ Packs/ day _____

Former Smoker? Y/N How long did you smoke? _____

Number of Packs/Day _____ How long since you quit? _____

Do you currently drink alcohol? Y/N If yes, how often? _____

Do you use illicit drugs? Y/N

Females Only:

Is there any possibility you are pregnant? _____ If so, how many weeks? _____

Date of last menstrual cycle _____

I have disclosed all of my known health history and information truthfully and to the best of my knowledge.

Patient

Signature _____ Date _____