

Welcome to Imagine Chiropractic

Dr. James M. Stites

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503-760-8648

Confidential Patient Data

PATIENT INFORMATION

Today's Date _____

Date of Birth _____ Age _____ Male Female _____

Patient's Legal Name: _____ Name you go by _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-mail _____

Preferred method of communications: Phone Text E-mail

Emergency Contact _____ Relationship to Patient _____

Phone _____

Your Occupation _____ Employer _____

Referred to this office by: Friends/Family Member - _____

Website Office Location Other _____

Payment of services will be by: Self Health Ins. Auto Ins. Workers Comp. Other

INSURANCE INFORMATION Copy of Insurance card required

Name of Insurance Co. _____ Subscriber ID _____

Name of Primary Insured _____ Relationship to Primary Insured: _____

Group No _____ Plan Name _____

Auto Accident/Workers Comp Claim _____

MEDICAL/FAMILY HISTORY S=Self M=Mother F=Father

S M F

- Aids
- Anemia
- Arthritis
- Asthma
- Back Pain
- Neck Pain
- Indigestion
- Diabetes
- Headaches
- Epilepsy

S M F

- Convulsion
- Reproductive issue
- Dislocated joints
- Bowel control
- Bladder trouble
- German measles
- Bone fracture
- Multiple Sclerosis
- Menstrual cramps
- High blood pressure

S M F

- HIV/ARC
- Kidney disorder
- Venereal disease
- Chest pain
- Serious Injury
- Nervousness
- Rheumatic fever
- Indigestion
- Heart trouble
- Muscular dystrophy

S M F

- Hepatitis
- Rheumatism
- Scarlet fever
- Concussion
- Sinus trouble
- Tuberculosis
- Numbness
- Polio
- Cancer

SURGICAL HISTORY

_____ Date _____

_____ Date _____

ACCIDENT HISTORY

Job Auto Other Injuries _____ Date _____

Job Auto Other Injuries _____ Date _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS

Please Rate Your Symptoms
(1-10, with 1 being the least serious)

- 1. _____
- 2. _____
- 3. _____
- 4. _____

SYMPTOMS ARE WORSE IN MORNING AFTERNOON NIGHT
WHEN AND HOW OCCURRED? _____

SYMPTOMS DEVELOPED FROM: JOB RELATED INJURY AUTO ACCIDENT ILLNESS UNKNOWN CAUSE
GRADUAL ONSET SUDDEN ONSET DATE OCCURRED _____

SYMPTOMS HAVE PERSISTED FOR # _____ HOUR(S) _____ DAY(S) _____ WEEK(S) _____ MONTH(S) _____ YEAR(S)
SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT
HAVE YOU EVER HAD THIS BEFORE: NO YES WHEN? _____
IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

HAVE YOU EVER HAD CHIROPRACTIC CARE? NO YES DOCTORS NAME _____
NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S): _____

ARE YOU ALLERGIC TO ANY MEDICATIONS NO YES WHAT KIND? _____
ARE YOU TAKING ANY MEDICATIONS NO YES WHAT KIND? _____
ARE YOU PREGNANT NO YES DATE OF LAST MENSTRUAL PERIOD _____
DATE OF LAST PHYSICAL _____ DATE OF LAST SPINAL X-RAY _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:
BENDING REACHING STRAINING AT STOOL COUGHING SITTING
TURNING HEAD TURNING IN BED LIFTING SNEEZING WALKING
LYING DOWN STANDING DRIVING GETTING UP FROM A SEAT
OTHER _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:
BENDING SITTING LIFTING STANDING LYING DOWN TURNING HEAD REACHING
WALKING APPLYING HEAT APPLYING COLD STRETCHING EXERCISE TAKING MEDICINE
OTHER _____

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:
blurred vision buzzing in ears cold feet cold hands cold sweats concentration loss /
confusion constipation depression /weeping spells diarrhea dizziness face flushed
fainting fatigue fever head seems too heavy headaches insomnia
light bothers eyes loss of balance loss of smell loss of taste low resistance to colds
muscle jerking numbness in fingers numbness in toes pins and needles in arms
pins and needles in legs ringing in ears shortness of breath stiff neck stomach upset
other _____

I authorize the release of information necessary to file insurance claims and to assign my medical benefits to Dr. James M. Stites. I am ultimately responsible for all charges incurred at Imagine Chiropractic and that my insurance is being billed as a courtesy.

Patient Signature: _____ Date: _____