PRAIRIE RIDGE
CHIROPRACTIC & REHAB

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Patient Information

Date_____ Sex: □ M □ F Age: _____
Patient_____
Address_____
_____
City State Zip Code

Birth Date_____ Height_____Weight_____

□Single □Married □Widowed □Separated □Divorced

Patient SS#_____
Occupation_____
Employer_____
Employer Address_____
Employer Phone #_____

Spouse's Name_____
Birth date_____ SS#_____
Occupation_____
Spouse's Employer_____
Whom may we thank for referring you?_____
_____

Insurance

Who is responsible for this account?_____
Relationship to Patient_____

Insurance Co_____
Group #_____

Is patient covered by additional insurance? □ Y □ N

Subscriber's Name_____
Birth Date _____SS#_____
Relationship to Patient_____
Insurance Co._____
Group #_____

_____
Responsible Party Signature

_____
Relationship Date

Phone Numbers

Home_____Work_____Cell_____
Best time and place to reach you:_____
_____
IN CASE OF EMERGENCY, CONTACT:
Name_____Relationship_____
Home Phone_____
Work Phone_____Ext_____
Email:_____

Accident Information

Is condition due to an accident? □ Y □ N Date_____
Type of accident □ Auto □ Work □ Home □ Other

To whom have you made a report of your accident?
□ Auto Insurance □ Employer □ Worker Comp □ Other
Attorney Name/Phone # (if applicable)_____
_____

Health History

What treatment have you already received for your condition?
□ Medications □ Surgery □ Physical Therapy □ Chiropractic Services □ None
□ Other_____

Name and address of other doctor(s) who have treated you for your current problem:_____

Date of Last: Physical Exam_____ Spinal X-Ray _____Blood Test_____
Spinal Exam_____ Chest X-Ray _____ Urine Test_____
Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Who is your primary care physician (First/Last Name)?_____
What is their address?_____
When was your last appointment with your primary doctor? _____
Was your last visit with your primary doctor related to your current problem? Yes No
Do you mind us contacting your primary doctor regarding your condition? Yes No

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV □ Y □ N
Alcoholism □ Y □ N
Allergy shots □ Y □ N
Anemia □ Y □ N
Anorexia □ Y □ N
Appendicitis □ Y □ N
Arthritis □ Y □ N
Asthma □ Y □ N
Bleeding Disorders
Breast Lump □ Y □ N
Bronchitis □ Y □ N
Bulimia □ Y □ N
Cancer □ Y □ N
Cataracts □ Y □ N
Chemical Dependency □ Y □ N
Chicken Pox □ Y □ N
Diabetes □ Y □ N
Emphysema □ Y □ N
Epilepsy □ Y □ N
Fractures □ Y □ N

Glaucoma □ Y □ N
Goiter □ Y □ N
Heart Disease □ Y □ N
Hepatitis □ Y □ N
Hernia □ Y □ N
Herniated Disc □ Y □ N
Herpes □ Y □ N
High Cholesterol □ Y □ N
Kidney Disease □ Y □ N
Liver Disease □ Y □ N
Measles □ Y □ N
Migraine Headaches □ Y □ N
Miscarriage □ Y □ N
Mononucleosis □ Y □ N
Multiple Sclerosis □ Y □ N

Mumps □ Y □ N
Osteoporosis □ Y □ N
Pacemaker □ Y □ N
Parkinson's Disease □ Y □ N
Pinched Nerve □ Y □N
Pneumonia □ Y □ N
Polio □ Y □ N
Prostate Problem □ Y □ N
Prosthesis □ Y □ N
Psychiatric Care □ Y □ N
Rheumatoid Arthritis □ Y □ N
Rheumatic Fever □ Y □ N
Scarlet Fever □ Y □ N
Stroke □ Y □ N
Suicide Attempt □ Y □ N

Thyroid Problems □ Y □ N
Tonsillitis □ Y □ N
TIA □ Y □ N
Tuberculosis □ Y □ N
Tumors Growths □ Y □ N
Typhoid Fever □ Y □ N
Ulcers □ Y □ N
Vaginal Infections □ Y □ N
Venereal Disease □ Y □ N
Whooping Cough □ Y □ N
Other_____
_____
_____
_____
_____

Exercise	Work Activity	Habits	
□ Never	□ Sitting _____ hrs/day	□ Tobacco	Packs/Day_____
□ Occasionally	□ Standing___ hrs/day	□ Alcohol	Drinks/Week_____
□ Frequently	□ Light Labor	□ Coffee/Caffeine Drinks	Cups/Day_____
□ Regularly	□ Heavy Labor	□ High Stress Level	Reason_____

Are you Pregnant? □ Yes □ No Date of last menstrual period_____ Due date_____
Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary, we would like to confirm that you are not pregnant at this time. _____ initial

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Car Accidents		

Medications/Uses	Allergies	Vitamins/Herbs/Minerals

Family History

If there is a family history of any of the following health conditions, please check the appropriate box corresponding to your maternal (mother's) or paternal (father's) side.

	Mother	Father		Mother	Father
Respiratory Disease	□	□	Cancer	□	□
Hypertension	□	□	Heart Disease	□	□
Gastro-Intestinal Disease	□	□	Osteoporosis	□	□
Diabetes	□	□	Thyroid Disease	□	□
Skin Disease	□	□	Degenerative Disc Disease	□	□
Neurological Disease	□	□	Stroke	□	□
Arthritic Disease	□	□	Genital-Urinary Disease	□	□