# Cornerstone Family Chiropractic

## Patient Information

Date ______________________________

SSN (Required for insurance) ______________________________

Patient Name ______________________________
Last Name

______________________________
First Name Middle Name

Address ______________________________

City ______________________________

State ______________ Zip ______________

Email ______________________________

Sex : Male Female Age ______________

Birthdate ______________________________

**Please Circle Answer:**

Married Widowed Single Minor

Separated Divorced Partnered for_____years

Occupation ______________________________

Employer/School ______________________________

Employer/School Phone ______________________________

Spouse's Name ______________________________

Do you have children? ______________________________

If yes, how many?______________________________

Whom may we thank for referring you?__________________

If not personally referred, how did you hear about our office?

______________________________

## Insurance

Who is responsible for this account? ______________________

Relationship to patient ______________________

Insurance Company ______________________

Group # ______________________

Subcriber id # ______________________

Insured's name ______________________

Insured's Birthdate ______________________

Insured's SSN ______________________

Insured's relationship to patient ______________________

Is patient covered by additional insurance? Yes No

Insurance company ______________________

Group # ______________________

Insured's info ______________________

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to Cornerstone Family Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________________
Signature of Patient, Parent, Guardian or Personal Representative

______________________________
Print name of Patient, Parent, Guardian or Personal Representative

______________ ______________
Date Relationship to Patient

## Phone Numbers

Home Phone (_____) ______________________

Cell Phone (_____) ______________________

Best time and place to reach you ______________________

IN CASE OF EMERGENCY, CONTACT

Name ______________________

Relationship ______________________

Contact Number (s) ______________________

## Medical Doctor Information

Who is your family medical doctor? ______________________

Name of their office ______________________

Office Address ______________________

Office Telephone ______________________

## Patient Condition

What symptoms are you having? ______________________________

When did your symptoms appear and how?______________________________

Is this condition getting progressively worse? ______________________________

Rate the severity of your pain an a scale from 0 (no pain) to 10 (severe pain). 1 2 3 4 5 6 7 8 9 10

Type of pain, circle all that apply: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Swelling

Is the pain constant or does it come and go? ______________ Is it worse in the morning or evening? ______________

Does it interfere with your (circle all that apply): Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform (circle all that apply): Sitting Standing Walking Bending Lying Down

# Health History - Please Complete Thoroughly

What treatment have you already received for your condition? ______________________________

______________________________

Name of Doctor (s) who have treated you for your condition ______________________________

Have you had prior chiropractic care? If so, when were you last seen? ______________________________

______________________________

Date of last: Physical Exam ____________ Spinal X-ray ____________ Blood Test ____________

Urine Test ____________ MRI ____________ CT/Bone Scan ____________

**Please circle any conditions you currently have or have had in the past**.

| | | | | | |
|---|---|---|---|---|---|
| AIDS/HIV | Alcoholism | Allergy Shots | Anemia | Anorexia | Appendicitis |
| Arthritis | Asthma | Bleeding Disorder | Breast Lump | Bronchitis | Bulimia |
| Cancer | Cataracts | Chicken Pox | Diabetes | Emphysema | Epilepsy |
| Fractures | Glaucoma | Goiter | Gonorrhea | Gout | Heart Disease/ Hypertension |
| Hepatitis | Hernia | Herniated Disk | Herpes | High Cholesterol | Kidney Disease |
| Liver Disease | Measles | Migraines | Miscarriage | Mono | Mulitple Sclerosis |
| Mumps | Osteoporosis | Pacemaker | Parkinson's | Pinched Nerve | Pneumonia |
| Polio | Prostate Problems | Prosthesis | Psychiatric Care | Rheumatoid Arthritis | Rheumatic Fever |
| Scarlet Fever | Stroke | Suicide Attempt | Thyroid Problems | Tonsilitis | Tuberculosis |
| Tumors | Typhoid Fever | Ulcers | Vaginal Infection | Venereal Disease | Whooping Cough |

**Please Circle any conditions that a family member has or has had:**

| | | | | | |
|---|---|---|---|---|---|
| Scoliosis | Disc Herniations | Heart Disease | Headaches | Arthritis | Stroke |

| EXERCISE - Please circle | WORK ACTIVITY | | HABITS | |
|---|---|---|---|---|
| None | Sitting | Twisting | Smoking | packs/day__________ |
| Light | Standing | Computer Work | Alcohol | Drinks/week__________ |
| Moderate | Light Labor | On Telephone | Coffee/Caffeine Drinks | Cups/Day __________ |
| Heavy | Heavy Labor | Distance Driving | High Stress Level | Reason__________ |
| Working with Trainer | Lifting | Flying/Travel | Eating | #meals per day__________ |

## FEMALES ONLY:

Are you or could you be pregnant? If so, when is your due date? ______________________________

Do you have regular menstrual cycles? ______________________________

Are your menstrual cycles painful or abnormal? ______________________________

With prior births did you have difficulty with delivery? ______________________________

**Please list all Injuries and/or surgeries you have had:**

| | | Date (s) |
|---|---|---|
| Falls | ______________________________ | __________ |
| Head Injuries | ______________________________ | __________ |
| Broken Bones | ______________________________ | __________ |
| Dislocations | ______________________________ | __________ |
| Surgeries | ______________________________ | __________ |
| Car Accidents | ______________________________ | __________ |

| Medications | Allergies | Vitamins/Supplements |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Signature:______________________________ Date: ____________