DATE: _____________ **BULLER CHIROPRACTIC CLINIC** ID#_______________

CONFIDENTIAL PATIENT INFORMATION

(PLEASE PRINT)

Full Name: ____ Name of Spouse or Guardian: ________________________________

Address: ____

Residence and Mailing City State Zip

Home Phone#: (_____) ___________________________ SS#:____

Cell Phone#: (_____) ____________________________ Email Address: ____

Birth Date: ___________________ # of Children: ______________ Pregnant? YES NO N/A

Occupation: _______________________________ Work Phone #: (______) ____

Employer's Name: ____

Spouse's Occupation/Employer: ____

Emergency Contact: ____ Phone#: (____) _______________________________

Are there any individuals (spouse, parent, etc.) with whom you would like to allow access to your health information if requested?

If so, please list: ____

Who may we thank for referring you to us? ____

List Medical Doctors consulted within the past year:

1. Name: __________________________________ City: ________________________Reason: ___________________________

2. Name: __________________________________ City: ________________________Reason: ___________________________

Family Doctor: _____________________________ Phone: ____

Date of last physical examination: ____

Have you ever been under chiropractic care before? NO YES: When? _____________ Who? ________________________________

What complaint(s) are you having in order of severity of pain or symptom?	Was this caused by an injury?	What started your pain? When did it start? How long have you had your pain?	Describe your pain. (i.e., Dull, Sharp, constant, off/on)
1.	YES/NO		
2.	YES/NO		
3.	YES/NO		
4.	YES/NO		

Have you had pain like this before? If yes, explain: ____

Have you found anything that makes your symptoms better (rest, morning, evening, certain positions…)?

YES NO If yes, explain: ____

Have you found anything that makes your symptoms worse (rest, morning, evening, certain positions…)?

YES NO If yes, explain: ____

Does your condition/pain awaken you from sleep? YES NO If yes, explain: _____________________________________

What position do you sleep in (on stomach, on back, on side…)? ____

Does your condition/pain affect your work activities? YES NO If yes, explain: _______________________________

Have you had any time loss from work or school? YES NO If yes, explain: ____________________________________

Do you have a history of tobacco use (cigarette, smokeless, etc.)? YES NO If yes, how much/how long? ___________________

Would you like information on how to quit? YES NO

Do you have any allergies to any food products or medications? YES NO If yes, please list: ________________________________

____

List any medications you are taking:

1. ____________________________________ Condition: ____________________________________

2. ____________________________________ Condition: ____________________________________

3. ____________________________________ Condition: ____________________________________

4. ____________________________________ Condition: ____________________________________

List any surgeries: (Please include all types)

1. Type: ____________________ When: __________________ Doctor: ______________________________

2. Type: ____________________ When: __________________ Doctor: ______________________________

3. Type: ____________________ When: __________________ Doctor: ______________________________

List any automobile accidents, sports injuries, or falls (especially those related to your present problems).

1. Type: _________________________ When: ______________________ Hospitalized? YES NO

2. Type: _________________________ When: ______________________ Hospitalized? YES NO

3. Type: _________________________ When: ______________________ Hospitalized? YES NO

NOTE: If you have RECENTLY been involved in an accident or injury, please request and fill out our accident report form, which may be obtained from the front desk.

Numbness in:	Pins and needles in:	**DR's COMMENTS:**
_____Arms R L	_____Arms R L	
_____ Hands R L	_____ Hands R L	
_____ Legs R L	_____ Legs R L	
_____ Feet R L	_____ Feet R L	

PLEASE CIRCLE THE FOLLOWING CONDITIONS YOU MAY HAVE OR HAVE EVER HAD:

ADD/ADHD	Depression	Gout	Menstrual Cramps	Pneumonia	Twitching of Face
Alcoholism	Diabetes	Hay Fever	Midback Pain	Polio	Whooping cough
Allergies	Diarrhea	Headaches	Migraine	Rheumatic Fever	Light Bothers Eyes
Arthritis	Dizziness	Heart Attack	Miscarriage	Ringing in ears	Pains in Arms/Hands
Asthma	Ear Infections	HIV	Multiple Sclerosis	Shortness of breath	Pains in Legs/Feet
Back Pain	Eczema	Intestinal Gas	Mumps	Sinus Trouble	Inflamed Throat
Backaches	Emphysema	Irritability	Neck Pain	Stomach Trouble	Irregular Periods
Cancer	Epilepsy	Kidney Trouble	Nervousness	Stroke	Arteriosclerosis
Chest Pains	Fainting	Loss of Balance	Neuritis	Swollen Joints	High Blood Pressure
Cold Sweats	Fatigue	Low Blood Sugar	Nose Bleeds	Thyroid Problems	Tightness of Shoulders/Neck
Constipation	Gall Bladder	Measles	Painful Joints	Tuberculosis	

DUE TO THE CONSTANT CHANGE IN INSURANCE, IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR OWN POLICY AND COVERAGE.

*** I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Buller Chiropractic Clinic may prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Buller Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. ***

Name of person responsible for payment: ____

Primary Insured's Name: ________________________________ DOB: ________/______________/__________
(If different than yours)

Patient Signature: ________________________________ Date: ______________________________

Guardian or Spouse's Name: ____________________________ Date: ______________________________

Information Taken By: ________________________________ Date: ______________________________