Gulf Coast Chiropractic New Patient Information

PATIENT INFORMATION

Date _____

Name _____

SS # _____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE #_(_____)_____

E-MAIL_____

SEX male female (circle) AGE_____

MARITAL STATUS ***Married*** ***Widowed*** ***Single*** ***Minor***

Separated ***Divorced*** ***Partnered***

PATIENT EMPLOYER/SCHOOL_____

EMPLOYER/SCHOOL ADDRESS_____

_____

EMPLOYER PHONE # (_____)_____

SPOUSE NAME _____

SPOUSE EMPLOYER_____

EMERGENCY CONTACT_____

EMERGENCY CONTACT # (_____)_____

INSURANCE CO_____ GROUP # _____

SUBSCRIBERS NAME_____

BIRTH DATE _____ SS # _____

HOW DID YOU HEAR ABOUT US? _____

PATIENT CONDITION

REASON FOR VISIT _____

WHEN DID YOUR SYMPTOMS APPEAR _____

IS THIS CONDITION DUE TO AN ACCIDENT_____ DATE_____

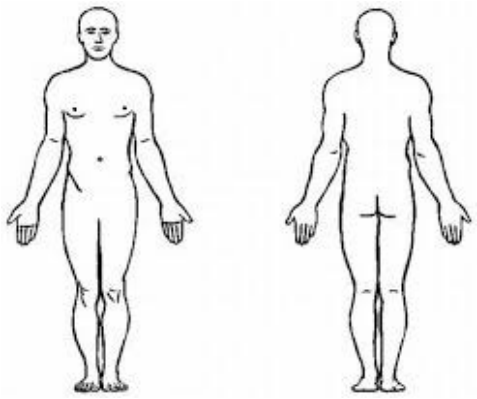
TYPE OF ACCIDENT (CIRCLE*)* *AUTO* *WORK* *HOME* *OTHER*

TO WHOM HAVE YOU MADE A REPORT OF YOUR ACCIDENT? (CIRCLE)

AUTO INSURANCE* *WORKER COMP* *EMPLOYER* *OTHER

ATTORNEY NAME (if applicable) _____

MARK AN "X" WHERE YOU ARE EXPERIENCING PAIN



RATE THE SEVERITY OF YOUR PAIN 10 BEING THE HIGHEST _____

CIRCLE THE ONE THAT BEST DESCRIBES YOUR PAIN

DULL* *SHARP* *THROBBING* *NUMBNESS* *ACHING
SHOOTING* *BURNING* *TINGLING* *STIFFNESS* *CRAMPS* *OTHER

HOW OFTEN DO YOU HAVE THIS PAIN? _____

IS IT CONSATANT OR COME AND GO_____

ACTIVITIES OR MOVEMENTS THAT ARE PAINFUL TO PERFORM (CIRCLE)

SLEEPING SITTING WALKING WORKING BENDING LYING DOWN