WAGNER CHIROPRACTIC

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PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: _____

PATIENT NAME: _____ _____ _____ DATE OF BIRTH: _____
LAST FIRST MI

AGE: ___ SEX: M ☐ F ☐

HOME ADDRESS: _____ CITY/STATE: _____
ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_____ YES ☐ NO ☐

WORK PHONE #: (____) ____-_____ YES ☐ NO ☐

CELL PHONE #: (____) ____-_____ YES ☐ NO ☐

E-MAIL: _____ YES ☐ NO ☐

PRIMARY LANGUAGE: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES ☐ NO ☐
IF YES, NAME: _____ RELATIONSHIP: _____
PHONE #: (____) ____-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____
PHONE #: (____) ____-_____

PRIMARY CARE DOCTOR: _____ WHO REFERRED YOU TO US? _____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR CLINICAL INFORMATION?
☐ YES NAME(S) _____

☐ NO

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____
ZIP: _____ PHONE #: (____) ____-_____

INSURANCE INFORMATION

ARE YOU ELIGIBLE FOR MEDICARE AND/OR MEDICAID? _____

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____
ZIP: _____ PHONE #: (____) ____-_____

PATIENT NAME: _____
DATE OF BIRTH: _____/_____/_____

INSURED NAME: _____ DATE OF BIRTH _____

EMPLOYER _____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____
CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

INSURED NAME: _____ DATE OF BIRTH _____

EMPLOYER _____

CONTRACT # _____ GROUP # _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ OTHER _____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	Y	N		Y	N		Y	N
ACID REFLUX	☐	☐	FIBROMYALGIA	☐	☐	NEUROPATHY	☐	☐
ANEMIA	☐	☐	GOUT	☐	☐	OPEN SORES	☐	☐
ARTHRITIS	☐	☐	HEART ATTACK	☐	☐	PNEUMONIA	☐	☐
ASTHMA	☐	☐	HEART DISEASE/FAILURE	☐	☐	POLIO	☐	☐
BACK TROUBLE	☐	☐	HEPATITIS	☐	☐	RHEUMATIC FEVER	☐	☐
BLADDER INFECTIONS	☐	☐	HIV+/AIDS	☐	☐	SICKLE CELL DISEASE	☐	☐
ABNORMAL BLEEDING	☐	☐	HIGH BLOOD PRESSURE	☐	☐	SKIN DISORDER	☐	☐
BLOOD CLOTS	☐	☐	KIDNEY DISEASE	☐	☐	SLEEP APNEA	☐	☐
BLOOD TRANSFUSION	☐	☐	LIVER DISEASE	☐	☐	STOMACH ULCERS	☐	☐
BRONCHITIS/EMPHYSEMA	☐	☐	LOW BLOOD PRESSURE	☐	☐	STROKE	☐	☐
CANCER	☐	☐	MIGRAINE HEADACHES	☐	☐	THYROID DISEASE	☐	☐
DIABETES	☐	☐	MITRAL VALVE PROLAPSE	☐	☐	TUBERCULOSIS	☐	☐
OTHER CONDITIONS:								

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

HAVE YOU HAD THIS CONDITION IN THE PAST? _____ IF YES, WHEN?

_____

_____

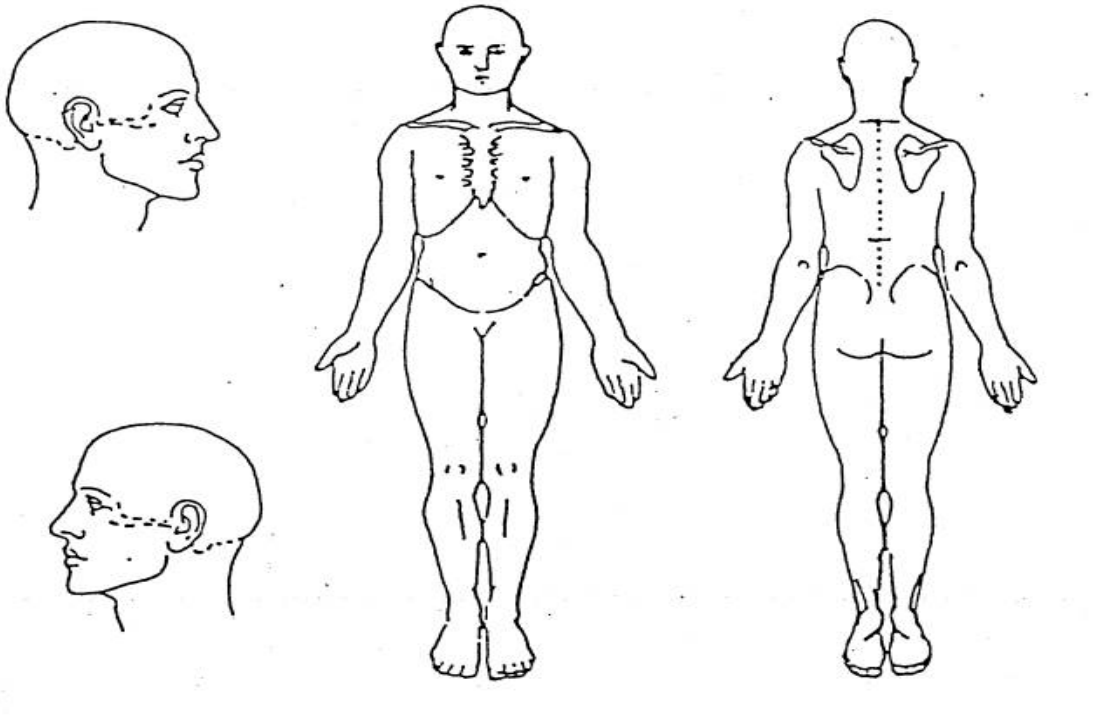
DID YOU SEEK TREATMENT BY A DOCTOR FOR THIS CONDITION? YES ☐ NO ☐

IF YES, BY WHOM? DR NAME: _____

PHONE NUMBER : _____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS ☐ / WEEKS ☐ / MONTHS ☐ / YEARS ☐

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CHECK)
(NO PAIN) 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES

PATIENT NAME: _____
DATE OF BIRTH: _____/_____/_____

☐ RESTING ☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____
SIGNATURE

_____
DATE