

About You

Today's Date:

Patient's Name:

What do you prefer to be called?:

Birth Date:

Age:

Social Security No.:

Mailing Address:

Home Phone:

Work Phone:

Cell Phone:

Email Address:

Referred By:

Occupation:

 Status: Minor Single Married
 Divorced Separated Widowed

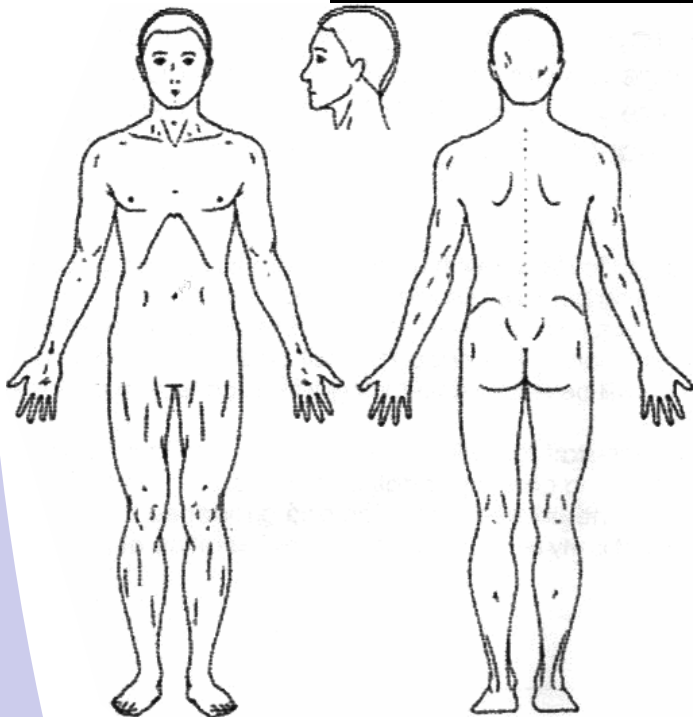
Spouse's Name:

Do you have Children: Yes No How many?

Emergency Contact: _____

Relation:

Phone:



Please circle your areas of pain on the figures above

Reason for Visit

The reason for this visit is a result of:

 Work Sports Auto Trauma Chronic

Explain what happened: _____

Please describe the pain & its location: _____

When did this condition begin:

Is this condition getting worse:

 Yes No Constant Comes & Goes

Is this condition interfering with your:

 Sleep Work Daily Routine

If so, please explain:

Have you had chiropractic care before: Yes No

If so, whom: _____

Phone:

Health History

Are you taking any of the following medications?

- Nerve Pills Pain Killers (including aspirin) Muscle Relaxers Stimulants
 Blood Thinners Tranquilizers Insulin Other(s) _____

Do you have or ever have had any of the following disease or conditions?

- Frequent Neck Pain Fainting/Seizures/Epilepsy
 Lower Back Problems Sinus Problems Asthma
 High/Low Blood Pressure Difficulty Breathing Arthritis
 Severe/Frequent Headaches Artificial Bones/Joints

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

List any past serious accidents with dates: _____

Family Health History: _____

Do you: Take supplements or vitamins? Yes No
Exercise? Yes No
Do you smoke? Yes No How Long? _____

Are you wearing: Inner Soles Heal Lifts Sole Lifts Arch Supports
What is the age of your mattress? _____ Is it comfortable: Yes No

For women: Are you taking birth control? Yes No
Are you pregnant? Yes No How Long? _____
Are you nursing? Yes No

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: ____/____/____

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“Life is Motion”