Welcome

FREEMAN CHIROPRACTIC CLINIC

PATIENT INFORMATION (Please Print)

Date

Name

Address

City

State Zip

SS #

Email

Sex: M F Date of Birth

Age Marital Status: M S W D

# of children Occupation

Employer/School

Employer/School Address

Spouse Name

Spouse's Occupation

Spouse's Employer

Referred By

PHONE NUMBERS

Home Phone

Cell Phone

Work Phone

INSURANCE

Insurance Company

Primary Insured name if other than yourself:

Primary Insured DOB

Group #

Insurance #

Is patient covered by additional insurance? Y N

Insurance Company

Insurance #

Group #

ACCIDENT INFORMATION

Is this condition due to an accident? Y N

If so, date of accident

Type of accident: Auto Work Home Other

In case of Emergency, Contact:

Name

Relationship

Home Phone

Cell Phone

Work Phone

PATIENT CONDITION

Purpose of this appointment (major complaint)

What activities aggravate your condition?

Is the condition getting progressively worse?

Is this condition interfering with your: Work Sleep Daily Routine Other

How long has it been since you really felt good?

Other Doctors you have seen for this condition?

What operations have you had?

Are you pregnant? Y N Due Date

Have you ever been under chiropractic care? Y N Doctors Name

Serious Illness?

(OVER)

HEALTH HISTORY

Have you ever suffered from:

________Allergy
________Poor posture
________Tuberculosis
________Itching
________Dizziness
________Sciatica
________Bruise easily
________Varicose veins
________Fatigue
________Spinal curvatures
________Hay fever
________Bed-wetting
________Headache
________Swollen joints
________Nosebleeds
________Frequent urination
________Loss of sleep
________Ear noises
________Enlarged thyroid
________Eye pain
________Failing vision
________Venereal disease

________Colon trouble
________Sinus infection
________Kidney infection
________Kidney stone
________Ulcers
________Diarrhea
________High blood pressure
________Prostate trouble
________Nervousness
________Depression
________Difficult digestion
________Low blood pressure
________Cramps or backache
________Numbness
________Hemorrhoids
________Pain over heart
________Anemia
________Stroke
________Chest pain
________Difficult breathing
________Pleurisy

________Arthritis
________Nausea
________Poor circulation
________Hot flashes
________Bursitis
________Asthma
________Rapid heart beat
________Irregular cycle
________Foot trouble
________Colds
________Slow heart beat
________Lumps in breast
________Low back pain
________Deafness
________Alcoholism
________Neck pain or stiffness
________Diabetes
________Polio
________Swelling of ankles
________Cancer
________Excessive menstrual flow

Tingling or numbness in:

________Shoulder
________Arms
________Elbows
________Hands
________Hips
________Legs
________Knees
________Feet

Exercise	**Work Activity**	**Habits**	
______None	______Sitting	______Smoking	Packs/Day________________
______Moderate	______Standing	______Alcohol	Drinks/Week________________
______Daily	______Light Labor	______Coffee/Caffeine Drinks	Cups/Day________________
______Heavy	______Heavy Labor	______High Stress Level	Reason________________
		______Hours of sleep	Sleep on back stomach side

Medications	**Allergies**	**Vitamins/Herbs/Minerals**

For Doctor Use Only