# Welcome to Performance Health Chiropractic

## Patient Information

Thank you for choosing Performance Health Chiropractic for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.
(please print clearly)

Name:_______________________________________________ **Soc Sec**#______________

Address:______________________________City:____________State:_____Zip:________

Sex: ❑Female ❑Male Birthdate:____________Email:_______________________________

Home Phone:_____________Cell Phone:_______________Work Phone:________________

Do you prefer to receive calls at: ❑Home ❑Work ❑Cell ❑No Preference

❑Married ❑Widowed ❑Single ❑Minor ❑Separated ❑Divorced ❑Partnered for_____years

❑Asian/Pacific Islander ❑Asian Indian ❑Black/African American

❑Caucasian/White ❑ Native American ❑ Latino/Hispanic ❑ Other

Patient Employer/School________________________________Occupation______________

Employer/School Address:__________________City:____________State:_____Zip:________

Spouse or parent's name:________________Employer:_____________Phone:___________

Whom may we thank for referring you to us?________________________________________

Person to contact in case of emergency:___________________________Phone:___________

## Responsible Party

***(If different than above)***

Name of person responsible for this account:________________________________________

Relationship to patient:___________________________________________Phone:____________

Address:______________________________City:___________State:_______Zip:________

Name of Employer:__________________________________________Work Phone:____________

## Insurance Information

Name of insured:______________________________ Relationship to patient:________________

Birthdate:__________ Phone:______________ Insurance Company:_______________________

ID#_______________________ Group#__________________

**Do you have additional insurance?** ❑Yes ❑No **If yes, please complete the following:**

Name of insured:______________________________ Relationship to patient:________________

Birthdate:__________ Phone:______________ Insurance Company:_______________________

ID#_______________________ Group#__________________

**CONFIDENTIAL**

## Symptoms

Reason for visit:________________________________ When did you first notice the symptoms?____________________

Is the condition getting progressively worse?___________ Where specifically is the problem(s) located?___________

Which activities are difficult to perform? ❑Sitting ❑Standing ❑Walking ❑Bending ❑Lying down ❑Other

Type of pain: ❑Sharp ❑Dull ❑Throbbing ❑Numbness ❑Aching ❑Shooting
❑Burning ❑Tingling ❑Cramps ❑Stiffness ❑Swelling ❑Other

Rate the severity of your pain. (1 = minimal pain or discomfort, to 10 = severe pain) 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go?____________________________________________
What treatment have you received for your condition?
❑Medication ❑Surgery ❑Physical Therapy ❑Other______________________________
Name and address of other doctor(s) who have treated you for your condition:
____________________________________________________________________________

## Health History

Check only those conditions which you are applicable______________________

| | | | | |
|---|---|---|---|---|
| ❑AIDS/HIV | ❑Cataracts | ❑Hepatitis | ❑Osteoporosis | ❑Suicide Attempt |
| ❑Alcoholism | ❑Chem. Dependency | ❑Hernia | ❑Pacemaker | ❑Thyroid Problem |
| ❑Allergy Shots | ❑Chicken Pox | ❑Herniated Disc | ❑Parkinson's Disease | ❑Tonsillitis |
| ❑Anemia | ❑Depression | ❑ High Cholesterol | ❑Pinched Nerve | ❑Tuberculosis |
| ❑Anorexia | ❑Diabetes | ❑Hypertension | ❑Pneumonia | ❑Tumors, Growths |
| ❑Appendicitis | ❑Emphysema | ❑Kidney Disease | ❑Polio | ❑Typhoid Fever |
| ❑Arthritis | ❑Epilepsy | ❑Liver Disease | ❑Prostate Problems | ❑Ulcers |
| ❑Asthma | ❑Fractures | ❑Measles | ❑Prosthesis | ❑Vaginal Infection |
| ❑Bleeding Disorders | ❑Glaucoma | ❑Migraine Headaches | ❑Psychiatric Care | ❑Venereal Disease |
| ❑Breast Lump | ❑Goiter | ❑Miscarriage | ❑Rheumatoid Arthritis | ❑Whooping Cough |
| ❑Bronchitis | ❑Gonorrhea | ❑Mononucleosis | ❑Rheumatic Fever | ❑Other_________ |
| ❑Bulimia | ❑Gout | ❑Multiple Sclerosis | ❑Scarlet Fever | _____________ |
| ❑Cancer | ❑Heart Disease | ❑Mumps | ❑Stroke | _____________ |

Date of last exams:______________________________________________________________
List any types of surgeries which you have had and the dates which they occurred:______________________
____________________________________________________________________________
Please list all medications you are currently taking:_____________________________________________
Allergies:___________________________________________________________________

(**Woman**) Are you pregnant? ❑Yes ❑No On what date did your last menstrual cycle begin?________________
Nursing? ❑Yes ❑No Taking Birth Control ❑Yes ❑No

## Daily Habits

What type of exercise do you perform on a daily basis? ❑None ❑Moderate ❑Heavy
What do your daily work habits include?_________________________________________________
What vitamins do you take?__________________ Nutritional Supplements?______________________________
Do you smoke? ❑Yes ❑No How much per day?_______________________________________________
How much liquor do you consume weekly?____________ How many caffeinated beverages do you drink per day?______

## Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with____________and assign directly to Performance Health Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Performance Health Chiropractic may use my health care information and may disclose such information to the above-named Insurance Company(ies)and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____________________________________________________ ____________________
Signature of Patient, Parent, Guardian or Personal Representative Date

____________________________________________________ ____________________
Please print the name of Patient, Parent, Guardian or Personal Representative Relationship to Patient