Patient Information Form

3108 Church Street • Stevens Point, WI 54481 • (715)341-0910

Date _____

Name _____ Date of Birth (DOB) _____ Age _____ Sex □ M □ F

Address _____ City_____ State _____ ZIP _____

SSN_____ E-mail _____

Home # _____ Cell # _____ Work #_____

Employer _____ Occupation _____

Marital Status □ Single □ Married □ Separated □ Divorced □ Widowed Number of Children_____

Spouse's Name _____ DOB_____

Spouse's Employer _____ Occupation _____

Emergency Contact Name_____ Relationship _____

Home # _____ Cell # _____ Work #_____

Whom may we thank for referring you? _____

PRESENT COMPLAINT(S) Worker's Comp □ Yes □ No Car Accident □ Yes □ No Other _____

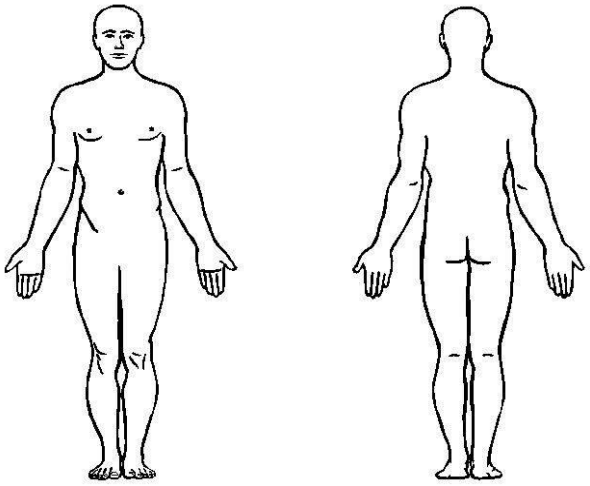
Reason for Visit _____

When did you first notice symptoms? _____

Is this condition getting progressively worse? □ Yes □ No □ Unknown

How did it happen? _____

Mark an X on the picture where you are experiencing symptoms.



Rate the severity of pain on a scale from 1 (mild) to 10 (severe) _____

Type of pain □ Sharp □ Dull □ Throbbing □ Numb □ Aching □ Shooting

□ Burning □ Tingling □ Cramping □ Stiffness □ Swelling □ Other

Is it constant or does it come and go? _____

What makes it feel better? _____

Activities/movements that are painful to perform? _____

What treatment have you already received from this problem? □ Meds □ Surgery □ Physical Therapy □ Other _____

Name of doctor(s) who have treated your for your condition _____

INSURANCE INFORMATION – PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD

Primary Insurance Co _____ Secondary Insurance Co _____

Assignment and Release - I understand and agree that health and insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that FORD CHIRPORACTIC CLINIC, SC will prepare any necessary forms to assist me in making collection from the insurance company and that any amount authorized is to be paid directly to FORD CHIRPORACTIC CLINIC, SC and will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment and any attorney fees and costs incurred to collect payment on those services. I hereby give my permission and consent for treatment at this office and authorize my physician to release information required to support my claim.

_____ _____ _____

SIGNATURE (If patient is a minor, parent or guardian is required to sign) Relationship to Patient Date

HEALTH HISTORY

Place a mark to indicate if you have had any of the following:

□ Alcoholism
□ Anemia
□ Anorexia/Bulimia
□ Arthritis
□ Asthma/Breathing Problems
□ Bleeding Disorder
□ Cancer _____
□ Cataracts
□ Chemical Dependency
□ Chest Pain
□ Communicable Disease(s)
□ Constipation
□ Diabetes
□ Diarrhea
□ Dizziness
□ Ears Ringing
□ Emphysema
□ Epilepsy/Seizures
□ Fainting
□ Fatigue
□ Glasses/contacts
□ Glaucoma
□ Gout
□ Headache/Migraine
□ Heart Attack/Disease
□ Hernia
□ Herniated Disc
□ High Blood Pressure
□ High Cholesterol
□ Hot/Cold Sweats
□ Kidney Disease
□ Liver Disease
□ Loss of hearing
□ Loss of memory
□ Loss of taste
□ Lyme's Disease
□ Multiple Sclerosis
□ Nausea
□ Neck Pain
□ Numbness
□ Osteoporosis
□ Pacemaker
□ Parkinson's
□ Pneumonia
□ Prostate Issues
□ Prosthesis _____
□ Psychiatric
□ Sinus Problems
□ Sleeping Problems
□ Stomach Upset
□ Stroke
□ Tension
□ Thyroid Issue
□ Transplant
□ Tumors/Growths
□ Ulcers
□ Weight loss/gain
□ Other _____
_____
_____

FAMILY HEALTH HISTORY

Father Medical Conditions: _____ □ Deceased Died From _____

Mother Medical Conditions: _____ □ Deceased Died From _____

Siblings Medical Conditions: _____ □ Deceased Died From _____

Other familial disease _____

EXERCISE	**WORK ACTIVITY**	**SOCIAL HABITS**	
□ None	□ Sitting	□ Tobacco Products	Packs/Week _____
□ Moderate	□ Standing	□ Former Smoker	Quit Date_____
□ Daily	□ Labor (□ Light or □ Heavy)	□ Alcohol	Drinks/Week_____

Are you pregnant? □ Yes □ No Due Date _____ Have you suffered any miscarriages □ Yes □ No How Many? _____

OTHER INJURIES (Please describe and list dates)

Fall(s) _____

_____

Head Injury(s)_____

_____

Broken Bones _____

_____

Dislocation(s) _____

_____

Surgery(s) _____

_____

Other _____

_____

_____

Medications/Supplements	**Reason for Taking**

Any known medication allergies? □ Yes □ No _____

_____