STARKWOOD CHIROPRACTIC

Patient Information & History

Name and Address

First Name: _____

Middle Name: _____

Last Name: _____

Street: _____ Apt # _____

City: _____

State: _____

Zip Code: _____

Phone Numbers

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email

Home Email: _____

Work Email: _____

Personal Information

Date of Birth: _____

Social Security: _____

Marital Status: _____

Language: _____

Race: _____

Ethnicity: _____

How do you prefer to be contacted?

(Circle one) ♦Cell Phone ♦Home Phone ♦Email

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

Whom may we thank for referring you to our office? _____

Insurance/Accident Information

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Policy Holder's Social Security: _____

Policy Holder's Employer & Address: _____

_____

Date of Accident: _____

Time of Accident: _____

Where did the accident happen? _____

Where did you feel pain? _____

Were you unconscious? _____

What are your symptoms? _____

Please mark the diagram to illustrate your symptoms:

Explain how your accident happened: _____

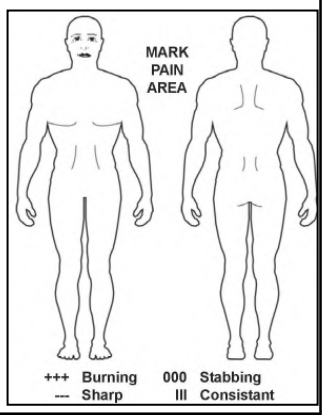
_____

_____

_____

_____

_____



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Health History Check only those conditions which are applicable:

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

Dates of last exams:_____

List any surgeries you have had and the dates:_____

Are you pregnant? _____

Please list all medications you are currently taking:_____

Allergies (Type and Reaction):_____

Daily Habits

What type of exercise do you perform on a daily basis?_____

What do your daily work habits include? (Ex: sitting, standing, light/heavy labor, computer work…)

_____

What vitamins do you currently take?_____

Do you smoke?_____ If yes, how much per day? _____

How much alcohol do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis?_____

Certification & Signature

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.

Patient's/Parent's/Guardian's Signature:_____ **Date:**_____