

# PATIENT INFORMATION FORM

"Achieving maximum output"



Chiropractic Sports Institute  
A Professional Corporation

(office use only)

Patient Number \_\_\_\_\_

Doctor \_\_\_\_\_

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Please complete all information

## ABOUT YOU

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ E-Mail address \_\_\_\_\_ DL # \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Male/Female Birthdate \_\_\_\_\_ Marital Status ( S M W D ) Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Spouse employer \_\_\_\_\_

Ages of your children \_\_\_\_\_

Referred to our office by \_\_\_\_\_ Person responsible for this account \_\_\_\_\_

## REASON FOR YOUR VISIT

What is your major complaint \_\_\_\_\_

Is this condition due to an: A) Auto Accident B) Work Injury C) Other Accident D) Unknown Cause E) Illness

Are the symptoms: A) Improving B) Getting Worse C) About the same D) Intermittent (come & go)

Date symptoms appeared \_\_\_\_\_

Circle any activities which aggravate your condition:

A) Standing B) Walking C) Sitting D) Lying E) Bending F) Lifting G) Twisting H) Coughing

Have you had these symptoms before? Y/N If so, when? \_\_\_\_\_

Have you seen another Doctor for this condition? A) MD B) DC C) DO D) None Drs. Name \_\_\_\_\_

Date Consulted \_\_\_\_\_ Were X-Rays taken \_\_\_\_\_ Date of X-Rays \_\_\_\_\_ Diagnosis \_\_\_\_\_

## EMERGENCY CONTACT

Who should we contact in case of an Emergency: \_\_\_\_\_

Relation to you \_\_\_\_\_ Home phone (\_\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_\_) \_\_\_\_\_

I understand and agree that health and accident Insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my Insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_