

WATERMAN CHIROPRACTIC CENTER

PATIENT INFORMATION

Name _____
Date _____
Address _____
City _____ State _____ ZIP _____
Home Phone _____
Cell Phone _____
Work Phone _____
Birthday _____ Age _____ Male Female
Employer _____
City you work at _____
Job Position _____
Marital Status: Married Single
 Divorced Separated Widowed
Social Security # _____
Driver's License # _____
E-mail Address _____
Payment Method: Cash Check Credit Card
C.C.# _____ Exp Date _____

SPOUSE/PARENT INFORMATION

Name _____
Employer _____
Work Phone _____
Type of Work _____

FAMILY INFORMATION

Number of Children _____
Names _____
Ages _____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

The purpose of this appointment is related to:

- Health/Wellness Sports Job Auto
 Fall Chronic Discomfort Home Injury
 Other Please Explain: _____

If job related, please note we do not handle worker's compensation cases.

When did this condition begin? _____

- Has this condition gotten worse
 stayed constant comes and goes

Does this condition interfere with: Work
 Sleep Daily routine Other activities

Explain _____

Has this condition occurred before? _____

Explain _____

Have you seen other doctors for this condition?

Doctor's Name(s) _____

Type of Treatment _____

Results _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a Chiropractor? _____

Reason for those visits? _____

Doctor's Name _____

Approximate Date of last visit _____

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that...

- | | | |
|---|-----|----|
| * Doctors of Chiropractic work with the nervous system? | Yes | No |
| * The nervous system controls all bodily functions and systems? | Yes | No |
| * Chiropractic is the largest natural healing profession in the world | Yes | No |
| * If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? | Yes | No |

HEALTH CONDITIONS

✓ **CHECK OFF** Problem(s) or condition(s) you have experienced in the past and

○ **CIRCLE** the Problem(s) or condition(s) which affect you currently:

HEAD:

- Headaches
- Sinus problems
- Dizziness
- Fainting
- Light-headedness
- Memory loss
- Loss of Vision
- Blurred vision
- Double vision
- Light sensitivity
- Loss of hearing
- Loss of taste
- Loss of balance
- Ear Pain
- Ringing in ears

NECK:

- Neck Pain
- Pain with movement
- Pinched Nerve
- Muscle spasms
- Grinding/popping sounds
- Arthritis

SHOULDERS:

- Pain in shoulder joint (R-L)
- Pain across shoulders
- Bursitis
- Arthritis
- Muscle spasms
- Pinched nerve in shoulder
- Frozen shoulder

ARMS & HANDS

- Pain in upper arm
- Pain in elbow
- Movement aggravated
- Pain in forearm
- Pain in hands
- Pain in fingers
- Pins and needles
- Numbness
- Fingers go to sleep
- Swelling
- Weakness
- Arthritis
- Hands cold
- Hands always moist

CHEST:

- Chest pain
- Difficulty breathing
- Rib pain
- Breast pain
- Irregular heartbeat

MID-BACK:

- Mid-back pain
- Pain between shoulder blades
- Scoliosis
- Muscle spasm
- Pain in kidney area

ABDOMEN:

- Digestive problems
- Nervous stomach
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids
- Ulcers/Colitis
- Stomach ache

LOW BACK:

- Low back pain
- Disc herniation
- Sciatica
- Scoliosis
- Arthritis
- Back spasms
- Pain with movement

HIPS, LEGS, & FEET:

- Buttock pain
- Hip joint pain
- Groin pain
- Cramps
- Knee pain
- Shin splints
- Leg numbness
- Ankle pain
- Swelling
- Pins and needles
- Foot pain
- Cold feet
- Sweaty feet

OTHER SYMPTOMS:

- Nervousness
- Irritable
- Depression
- Fatigue
- Sleep problems
- Cough/Cold
- Allergies _____
- _____
- Other symptoms: _____
- _____
- _____
- _____

GENERAL:

- High blood pressure
- Diabetes
- Heart problems
- Pacemaker
- Asthma
- Anemia
- Hepatitis
- Tuberculosis
- Kidney problems
- Cancer
- Chemotherapy
- Alcohol/drug abuse
- Psychiatric
- Thyroid problems
- Hormonal problems
- Herpes
- Shingles
- Venereal disease

WOMEN ONLY:

- Menstrual pain
- Cramping
- Irregular cycles
- Birth control
- Hysterectomy
- Menopause
- Pregnancy
- Nursing
- Breast Implants

MEN ONLY:

- Prostate pain
- Frequent urination
- Difficult urination

HEALTH HABITS:

- Smoking _____ /day
- Alcohol _____ drinks/day
- Coffee _____ cups/day
- Tea _____ cups/day
- Water _____ glasses/day
- Gain weight _____ lbs.
- Exercise: None Daily
 Moderate Intense

MEDICATIONS: (NAME)

- Pain Killers _____
- Nerve Pills _____
- Muscle relaxants _____
- Blood pressure _____
- Insulin _____
- Blood thinners _____
- Other _____
- Other _____
- Other _____

HEALTH CARE GOALS

Chiropractors are utilized for a variety of health care goals. Some people go for pain relief, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care**—Symptomatic relief of pain or discomfort
- Corrective Care**—Correcting and relieving the cause of the problem as well as the symptoms
- Comprehensive Care**—Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care
- I want the Doctor to select the type of care appropriate for my condition.

Patient Signature

Date

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments and/or adjunctive therapy as he or she deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I will be responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I terminate my care, any fees for professional services rendered me will become immediately due and payable.

Patient Signature

Date

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's office will prepare any necessary forms to assist me in collecting from my insurance company. Any refund check sent to Waterman Chiropractic Center will be credited to my account on receipt, or a refund check will be sent directly to me if my account balance is zero.

Patient Signature

Date

PLEASE PRESENT YOUR INSURANCE CARD TO OUR STAFF

EMERGENCY CONTACT

Name _____

Relationship _____

Home Phone _____

Work Phone _____

Cell Phone _____

PAIN DRAWING

Name: _____ Date: _____

Tell us where you hurt.

Please read carefully:

Mark the areas on your body where you feel your pain. Use the appropriate symbol(s) listed below.

Ache > > > >
> > > >

Numbness = = = =
= = = =

Pins & needles o o o o
o o o o

Burning x x x x
x x x x

Stabbing / / / / /
/ / / / /

Throbbing — — — —
— — — —

Right

Left

Left

Right

