

# PATIENT INTRODUCTION CARD

Date: \_\_\_\_\_ Patient # \_\_\_\_\_

Patient Name: Last \_\_\_\_\_ First \_\_\_\_\_ Init. \_\_\_\_\_

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

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ No. of Children \_\_\_\_\_ Are You Pregnant At This Time? Yes \_\_\_\_\_ No \_\_\_\_\_

Referred By: \_\_\_\_\_ Patient Social Security #: \_\_\_\_\_

Patient Employed By: \_\_\_\_\_

Occupation: \_\_\_\_\_ Business Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Have you ever had same or similar complaint? YES \_\_\_\_\_ NO \_\_\_\_\_

Condition Related To: Employment \_\_\_\_\_ Auto \_\_\_\_\_ Other \_\_\_\_\_

Explain: \_\_\_\_\_

Failure to notify us may jeopardize your claim.

Briefly describe Chief Complaint (Symptoms) \_\_\_\_\_

How Did it Happen \_\_\_\_\_

Other Symptoms \_\_\_\_\_

Past Surgery \_\_\_\_\_

What Medication Are You Taking? \_\_\_\_\_

Type of Health Insurance: Blue Cross/Blue Shield \_\_\_\_\_ Medicare \_\_\_\_\_

Medicaid \_\_\_\_\_ Other, Name: \_\_\_\_\_

Do You Have Major Medical Reimbursing Insurance: YES \_\_\_\_\_ NO \_\_\_\_\_

Name of Major Medical: \_\_\_\_\_

Are You Claiming Workmen's Compensation: YES \_\_\_\_\_ NO \_\_\_\_\_

Are You Claiming Auto Accident: YES \_\_\_\_\_ NO \_\_\_\_\_

Company or Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Attorney Name and Phone #: \_\_\_\_\_

- I Am Interested in Only Symptomatic Relief
- I Am Interested in Symptomatic Relief and Maximum Correction of My Problem
- After My Problem is Corrected I Am Interested in the Chiropractic Total Health Maintenance Program
- I Have No Specific Health Problem But I Am Interested in the Chiropractic Total Health Maintenance Program.

Signature on File: \_\_\_\_\_

Do You Have Any Problems With The Following  PRESENT  PAST

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Loss of balance                  | <input type="checkbox"/> Low blood pressure     | <input type="checkbox"/> Menstrual cramps & pain  |
| <input type="checkbox"/> Shooting head pains    | <input type="checkbox"/> Ringing in ears                  | <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Menstrual irregularity   |
| <input type="checkbox"/> Sinus trouble          | <input type="checkbox"/> Wear glasses                     | <input type="checkbox"/> Rheumatic fever        | <input type="checkbox"/> Diabetes                 |
| <input type="checkbox"/> Loss of smell          | <input type="checkbox"/> Lights bother eyes               | <input type="checkbox"/> Nervous stomach        | <input type="checkbox"/> Cancer                   |
| <input type="checkbox"/> Hayfever               | <input type="checkbox"/> Muscle spasms in neck            | <input type="checkbox"/> Stomach trouble        | <input type="checkbox"/> Sleeping problems        |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Grating in neck                  | <input type="checkbox"/> Ulcers                 | <input type="checkbox"/> Painful joints           |
| <input type="checkbox"/> Loss of taste          | <input type="checkbox"/> Neck pain                        | <input type="checkbox"/> Mid back pain          | <input type="checkbox"/> Swollen joints           |
| <input type="checkbox"/> Tightness of throat    | <input type="checkbox"/> Tightness of shoulder muscles    | <input type="checkbox"/> Nerves and nervousness | <input type="checkbox"/> Arthritis                |
| <input type="checkbox"/> Inflammation of throat | <input type="checkbox"/> Neuritis in shoulders and arms   | <input type="checkbox"/> Inner tension          | <input type="checkbox"/> Slipped disc             |
| <input type="checkbox"/> Thyroid trouble        | <input type="checkbox"/> Pins and needles in arms & hands | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Low Back Pain            |
| <input type="checkbox"/> Face flushed           | <input type="checkbox"/> Cold hands                       | <input type="checkbox"/> Cold sweats            | <input type="checkbox"/> Pinched nerves in back   |
| <input type="checkbox"/> Twitching of face      | <input type="checkbox"/> Chest pains                      | <input type="checkbox"/> Liver trouble          | <input type="checkbox"/> Pins and needles in legs |
| <input type="checkbox"/> Loss of memory         | <input type="checkbox"/> Shortness of breath              | <input type="checkbox"/> Gall bladder trouble   | <input type="checkbox"/> Swollen ankles           |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> T.B.                             | <input type="checkbox"/> Indigestion            | <input type="checkbox"/> Cold feet                |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Heart Pain                       | <input type="checkbox"/> Intestinal gas         | <input type="checkbox"/> Pains in legs & feet     |
| <input type="checkbox"/> Head feels too heavy   | <input type="checkbox"/> Heart palpitation                | <input type="checkbox"/> Constipation           |   |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Heart attacks                    | <input type="checkbox"/> Kidney trouble         |   |
| <input type="checkbox"/> Fainting               | <input type="checkbox"/> High blood pressure              | <input type="checkbox"/> Bladder trouble        |   |

ANY FALLS, ACCIDENTS, INJURIES?  YES  NO  
If yes, please explain \_\_\_\_\_