Patient Information

Name_____ Date_____

Sex_____ Marital Status _____ Date of Birth _____ Age_____

Cell Phone_____ Cell Phone Provider _____

Can we text you appointment reminders? Yes___ No___

Email_____

Address_____ City_____ State_____ Zip_____

Occupation_____ Employer_____ Full-time___ Part-time___

Does your work have you mostly: Sitting ___ Standing ___ Moving around___ **(*Mark all that apply*)**

Emergency Contact_____Phone_____

How did you hear about our office?_____

Briefly describe your Primary Complaint_____

_____

Any other complaints_____

List other doctor(s) seen for these condition_____

Have you ever been to a chiropractor before? Yes _____ No _____

Please list the chiropractor(s) and what city they practice in _____

When was your last chiropractic visit _____

Is your visit due to an accident? Yes____ No____ If yes, please describe_____

_____

If yes, do you plan to file a personal injury case or filing for insurance reimbursement?

Yes ____ No____

Headaches

Frequency (Ex. 2x/week): _____

Please describe associated symptoms: _____

_____

Neck Pain

Frequency (Ex. 2x/week): _____

Please describe associated symptoms: _____

_____

Personal Medical

History (Please check all boxes below that apply to your medical history.)

Current	Past	C	P	C	P
☐	☐ Headaches	☐	☐ High Blood Pressure	☐	☐ Diabetes
☐	☐ Neck Pain	☐	☐ Heart Attack	☐	☐ Excessive Thirst
☐	☐ Upper Back Pain	☐	☐ Chest Pains	☐	☐ Frequent Urination
☐	☐ Mid Back Pain	☐	☐ Smoking/Tobacco Use	☐	☐ Stroke
☐	☐ Low Back Pain	☐	☐ Drug/Alcohol Abuse	☐	☐ Angina
☐	☐ Shoulder Pain	☐	☐ Vaping	☐	☐ Allergies
☐	☐ Elbow/Upper Arm Pain	☐	☐ Kidney Disorders/Stones	☐	☐ Depression
☐	☐ Wrist/Hand Pain	☐	☐ Bladder Infection	☐	☐ Painful Urination
☐	☐ Epilepsy	☐	☐ Hip Pain	☐	☐ HIV/AIDS
☐	☐ Ulcer	☐	☐ Upper Leg Pain	☐	☐ Prostate Problems
☐	☐ Hepatitis	☐	☐ Knee Pain	☐	☐ Abnormal Weight
☐	☐ Pregnancy	☐	☐ Ankle/Foot Pain	☐	☐ Loss of Appetite
☐	☐ Dizziness	☐	☐ Jaw Pain	☐	☐ Abdominal Pain
☐	☐ Asthma	☐	☐ Joint Pain/Stiffness	☐	☐ Arthritis
☐	☐ Dermatitis/Eczema/Rash	☐	☐ Chronic Sinusitis	☐	☐ Cancer
☐	☐ Rheumatoid Arthritis	☐	☐ Loss of Bladder Control	☐	☐ Arthritis
☐	☐ Visual Disturbances	☐	☐ ADD/ADHD	☐	☐ Fatigue
☐	☐ Birth Control Pills	☐	☐Loss of Sleep	☐	☐ Tension
☐	☐Liver/Gall Bladder Disorder	☐	☐ Irritability	☐	☐ Nervousness

Please list any other diagnosed conditions _____

Describe any operations or surgeries you've had and the dates _____

_____

_____

Have you been treated by a physician for any health condition in the last year? Yes___ No___

Describe Condition_____

Are you currently taking any medication? Yes___ No___

Please list all medications (Rx and otc), dosage, and condition being treated:

_____

_____

_____

_____

_____

Are you currently pregnant? Yes___ No___ Any Previous pregnancies (#) _____

Any children? (Please list number and ages.)_____

_____

I agree that all the information above is true to the best of my knowledge. Any false statements made may result in dismissal of your case.

Every patient is responsible for paying any due balance according to the services that have been provided. Each patient will be given an updated fee schedule prior to any services. According to the policies of Functional Chiropractic, all payments are due prior to treatment, unless other arrangements have been made with Dr. Porter.

I, _____, have received the fee schedule and agree to these terms.
(Please Sign Here)

Date _____