BINDL FAMILY CHIROPRACTIC

CONFIDENTIAL PATIENT INFORMATION

Date _____ Home Phone ( ) _____

Name _____ Social Security ☐☐☐ ☐☐ ☐☐☐☐ Work Phone ( ) _____ Cell Phone ( ) _____

Address _____

City _____ Zip Code _____ E-mail _____

Age _____ Birth Date _____ Sex: M F Marital: M S W D

How Many Children? ___ Names & Ages _____

Occupation _____ Employer _____

Address: _____ Office Phone _____

Name of Spouse (or Parent if Minor) _____ Work Phone _____

Spouse's Employer _____ Address _____ Phone _____

Name of Emergency Contact _____ Address _____ Phone _____

Whom may we thank for referring you? _____

Purpose of this appointment / current problem _____

Other doctors seen for this condition _____

Is the condition due to injury or sickness arising out of employment or auto accident? _____

Date symptoms appeared or accident happened: _____ Days lost from work? ( ) YES ( ) NO

Explain what happened: _____

Is the condition getting worse? ( ) YES ( ) NO ( ) Constant ( ) Comes & Goes

What makes condition - better: _____

worse: _____

Severity of pain: No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Do you suffer from:

1. Dizziness _____	7. Neck Pain _____	12. Shoulder/Arm Pain _____	17. Nervousness _____
2. Back Pain _____	8. Arthritis _____	13. Hip/Leg Pain _____	18. Sinus Trouble _____
3. Heart Trouble _____	9. Headaches _____	14. Urinary Problems _____	19. Male / Female Troubles _____
4. Diabetes _____	10. Numbness _____	15. Digestive Disorders _____	20. Cancer _____
5. Stroke _____	11. Fainting _____	16. Epilepsy _____	21. Respiratory Problems _____

6. Blood Pressure ( ) HIGH ( ) LOW

7. Pregnant ( ) YES ( ) NO Do you have a pacemaker? ( ) YES ( ) NO

Have you been treated for any health condition by a physician in the last year: ( ) YES ( ) NO

Describe: _____

Date of last physical examination _____

Past Health History

List of previous surgeries with dates: _____

_____

List current medications: _____

_____

List the approximate dats of any accidents, operations or serious injuries (including broken bones) you have had: _____

_____

Major illnesses: _____

Do any of your family members have any diagnosed conditions? _____

_____

Habits

- ☐ Smoking packs/day _____
- ☐ Drinking
- ☐ Caffeine Amount/ Day _____

Exercise

- ☐ None
- ☐ Moderate
- ☐ Daily

Nutrition

- ☐ Poor
- ☐ Moderate
- ☐ Good

Supplements/Vitamins: _____

_____

Insurance Information

Type of Insurance: ☐ Health ☐ Worker's Comp. ☐ Automobile ☐ Cash

Insurance Company's Name and Address: _____

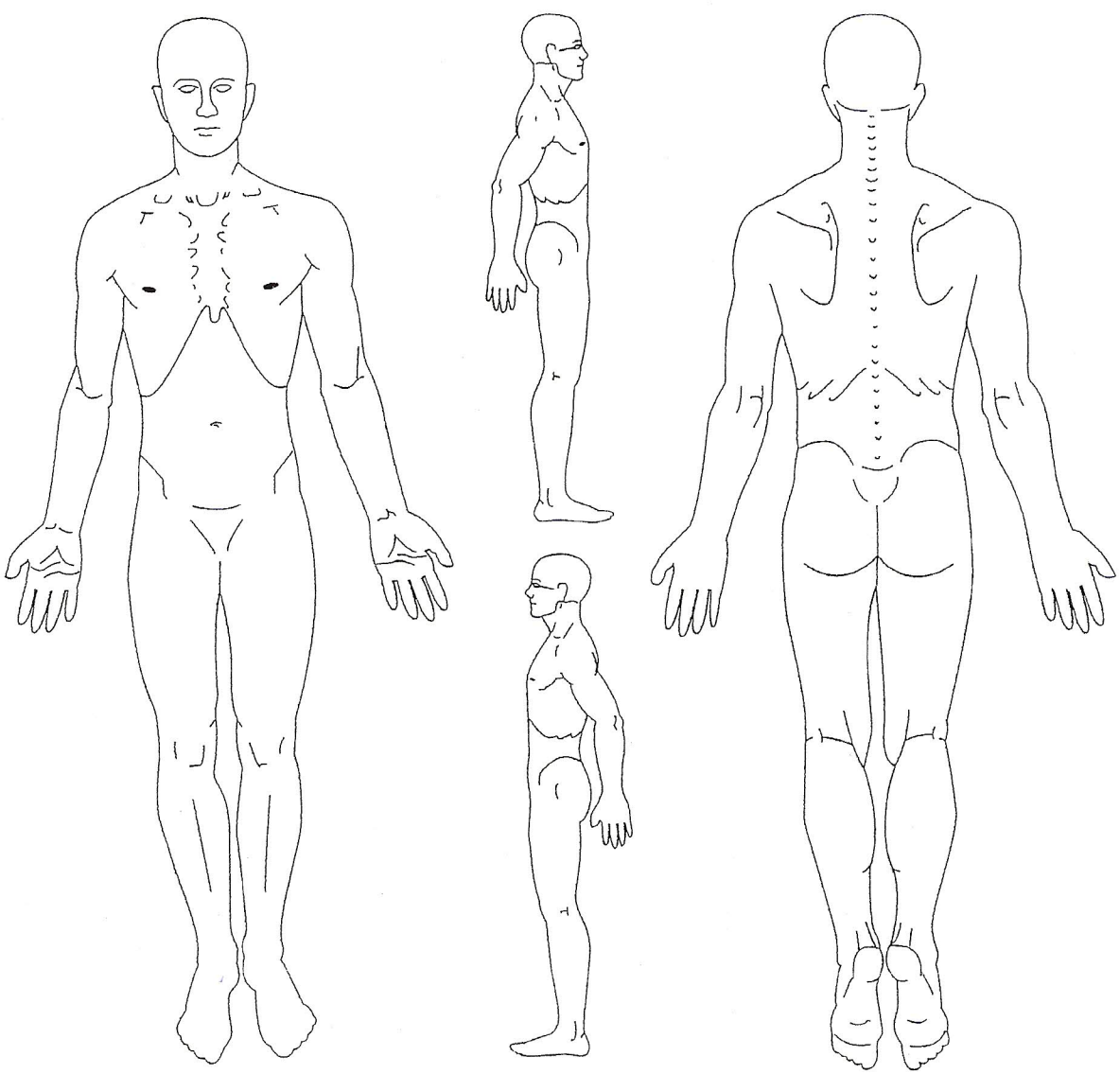
_____

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Signature: _____ Date: _____

Plese draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping



Review of Systems

Please check the appropriate circle for any of the following symptoms or conditions you are now experiencing or have had previously.

THE IS A CONFIDENTIAL HEALTH REPORT.

MUSCLE & JOINT

- ○ Arthritis
- ○ Back Pain (Lower)
- ○ Back Pain (Upper)
- ○ Bursitis
- ○ Neck Pain / Stiffness
- ○ Pain between Shoulders
- ○ Arm Pain / Numbness
- ○ Elbow Pain / Numbness
- ○ Swollen Joints
- ○ Hand, Wrist Pain / Numbness
- ○ Hip Pain / Numbness
- ○ Leg Pain / Numbness
- ○ Knee Pain / Numbness
- ○ Foot, Ankle Pain / Numbness
- ○ Sciatica
- ○ _____

RESPIRATORY

- ○ Chest Pain
- ○ Chronic Cough
- ○ Difficult Breathing
- ○ Spitting up Blood
- ○ Spitting up Phlem
- ○ Wheezing
- ○ Asthma
- ○ _____

GASTRO-INTESTINAL

- ○ Colon Trouble
- ○ Constipation/ Diarrhea
- ○ Difficult Digestion
- ○ Distension of Abdomen
- ○ Gallbladder Trouble
- ○ Hemorrhoids
- ○ Liver Trouble
- ○ Stomach Pain
- ○ _____

SKIN

- ○ Bruise Easily
- ○ Dryness
- ○ Eruptions / Rash
- ○ Varicose Veins
- ○ _____

EYES / EARS / NOSE / THROAT

- ○ Colds
- ○ Cataracts
- ○ Hearing Aids
- ○ Earache / Ear Discharge
- ○ Blurred Vision
- ○ Nasal Obstruction
- ○ Nosebleeds
- ○ Sinus Infection
- ○ _____

CARDIO-VASCULAR

- ○ Throat Infection
- ○ Hardening of Arteries
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Pain Over Heart
- ○ Poor Circulation
- ○ Rapid Heart Beat
- ○ Slow Heart Beat
- ○ Swelling of Ankles
- ○ _____

GENITO-UNINARY

- ○ Bed-wetting
- ○ Bladder Problems
- ○ Blood / Pus in Urine
- ○ Frequent Urination
- ○ Kidney Problems
- ○ Painful Urination
- ○ Prostate Problems
- ○ _____

FOR WOMEN ONLY

- ○ Cramps or Backache
- ○ Menstrual Problems
- ○ PMS
- ○ Irregular Cycle
- ○ Menopausal Symptoms
- ○ Are you Pregnant
- ○ Taking Birth Control
- ○ _____