Alpine Chiropractic Center

Patient Information

Date: _____

Patient Name: _____
Last First MI

What you prefer to be called: _____

Address: _____

City/State/Zip: _____

Cell Phone:_____

Home Phone:_____

Referred By:

Sex: ☐ **M** ☐**F** **Age:**_____**Birthdate:**_____

SSN:_____

Occupation: _____

Patient Employer/School: _____

Would you like to receive text or email reminders about your appointments?

☐ **Text: Cell Carrier:**_____

☐ **Email Address:**_____

In Case of Emergency, Contact:

Name:_____

Relationship:_____

Phone: (_____)_____

Accident Information

Is condition due to recent accident?:

☐ ***Yes*** ☐ ***No*** ***Date:*** _____

If yes, to whom have you made a report to?:

☐ ***Auto Insurance*** ☐ ***Employer***

☐ ***Worker's Comp*** ☐ ***Other***

Cause of Injury:_____

_____

When did your symptoms appear?_____

Is it getting progressively worse?_____

Mark an X on the picture where you have pain, numbness or tingling.

Type of pain: ☐***Sharp*** ☐***Dull*** ☐***Throbbing***
☐***Numbness*** ☐***Aching*** ☐***Shooting*** ☐***Burning***
☐***Tingling*** ☐***Cramps*** ☐***Stiffness*** ☐***Swelling***

How often do you have this pain?_____

Is it constant or comes and goes?_____

Does it interfere with:

☐***Work*** ☐***Sleep*** ☐***Daily Activity*** ☐***Recreation***

Activities or movements that are painful:

☐***Sitting*** ☐***Standing*** ☐***Walking***

☐***Bending*** ☐***Laying down***

Rate your pain 1(least pain) to 10(severe):_____

Insurance Information

Policy Holder: _____**D.O.B.**_____

Insurance Co: _____

Policy #: _____

Consent to Treatment of a Minor

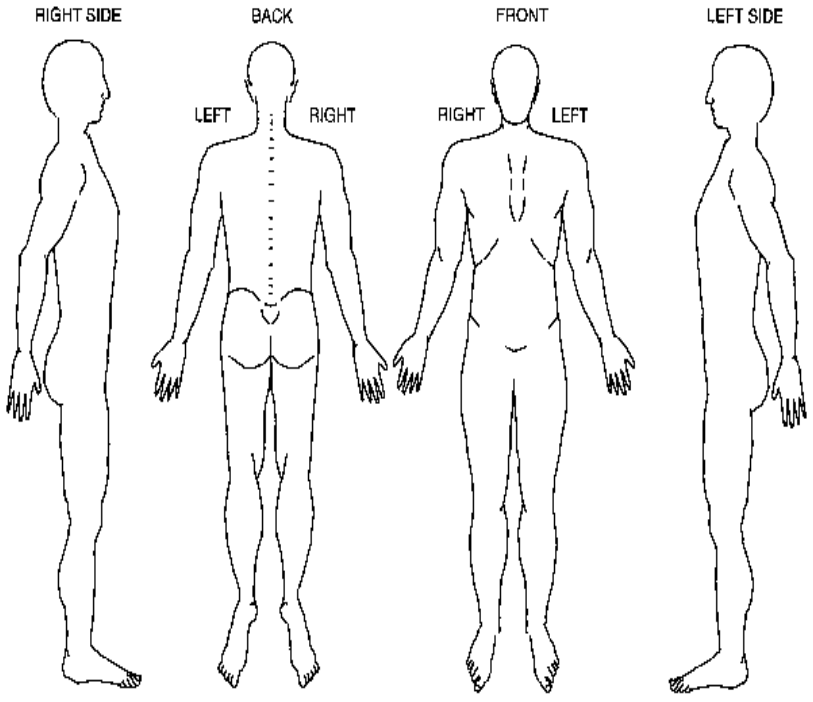
I hereby authorize *Alpine Chiropractic Center* and whomever they may designate as assistants to administer chiropractic care as deemed necessary to _____
Name of Child

Print Name: _____

Signature: _____

Relationship:_____

Patient Condition



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Alpine Chiropractic Center

Health History

Have you ever been treated by a chiropractor? ☐ Yes ☐ No If yes, Dr./Clinic name:_____
Date of last: Spinal X-ray_____ MRI, CT-Scan, Bone Scan of Spine_____

Herniated Disk	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Stroke/Heart Attack	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	AIDS/ HIV	☐ Yes ☐ No
Migraine Headaches	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Other	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	_____	
Hernia	☐ Yes ☐ No	Tumors, Growth	☐ Yes ☐ No	_____	
Bleeding Disorders	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	_____	

Exercise

☐ None ☐ Weekly
☐ Daily ☐ Monthly

Work Activity

☐ Sitting ☐ Standing
☐ Light Labor ☐ Heavy Labor

Habits

☐ Smoking Packs Per Day_____
☐ Alcohol Drinks/Week_____
☐ Coffee/Caffeine Cups/Day_____
☐ High Stress Level Reason_____

Are you pregnant? ☐ *Yes* ☐ *No* Due Date:_____
OB/GYN or Midwife Name: _____

Injuries/Surgeries you have had:

	Description	Date
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications Reason

_____
_____
_____
_____

Allergies

_____
_____
_____
_____

- **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.**
- **I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.**
- **I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.**
- **I authorize ACC to send information regarding my account, appointments or other information I request via email or text.**

Signature _____ Date_____