PATIENT PAPERWORK

REUTER
CHIROPRACTIC
EST. 1981

Date:

E-mail

Last Name

First Name

MI

Street Address

City

State

Zip

Cell Phone

Home Phone

Birth Date

Age

Height

Weight

Sex

- ◯ Male
- ◯ Female

Number of Children

Marital Status

- ☐ S
- ☐ M
- ☐ D
- ☐ W

Spouses Name

How were you referred to our office?

- ☐ Insurance Company
- ☐ Website
- ☐ Advertising
- ☐ Patient Referral

Do you have insurance?

- ◯ Yes
- ◯ No

Insurance Company Name

Member ID

Group Number

What is your Major Complaint?

Is this condition due to:

- ☐ Auto Accident
- ☐ Work Injury
- ☐ Other Accident
- ☐ Illness
- ☐ Unknown Cause

Are these symptoms:

- ☐ Improving
- ☐ Getting Worse
- ☐ About the Same
- ☐ Intermittent (come and go)

Date Symptoms Appeared

Check any activities which aggravate your condition:

☐ Standing ☐ Walking ☐ Lying ☐ Bending ☐ Lifting
☐ Twisting ☐ Coughing ☐ Other

Have you had these symptoms before?

◯ Y ◯ N

If so when?

Describe the pain (select all that apply)

☐ Achy ☐ Sharp/Shooting ☐ Pins and Needles
☐ Other

Does pain radiate into your arms and legs? (select all that apply)

☐ Left Leg ☐ Right Leg ☐ Left Arm ☐ Right Arm

Is the pain:

- ☐ Constant
- ☐ Intermittent

Have you seen another doctor for this condition?

☐ M.D. ☐ Chiropractor ☐ Physical Therapist
☐ Other

Previous treatment tried/failed (select all that apply)

- ☐ Advil/Tylenol/Aleve
- ☐ Prescription Pain Medication
- ☐ Injections
- ☐ Chiropractic
- ☐ Massage

Do you have a pacemaker and/or atrial defibrillator?

- ◯ Y
- ◯ N

Women; Are you currently pregnant?

- ◯ Y
- ◯ N

PAST MEDICAL HISTORY

Chronic Conditions

- ☐ Diabetes
- ☐ Rheumatoid Arthritis
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ High Blood Pressure
- ☐ Asthma

Have you had joint replacement surgery?

◯ Y ◯ N

If yes, please list surgery type and date:

Have you had spinal surgery?

◯ Y ◯ N

If yes, please list surgery type and date:

Do you have any other medical conditions/issues the doctor should know about?

SOCIAL HISTORY

Do you currently smoke cigarettes?

- ◯ Y
- ◯ N

Have you ever smoked cigarettes?

- ◯ Y
- ◯ N

Do you consume more than 1-2 alcoholic beverages per day?

- ◯ Y
- ◯ N

Signature

Date