



### Chiropractic Plus, P.C.

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(219) 738-1925      (219) 464-1100  
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#### Confidential Patient Information

Date \_\_\_\_\_

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex M F  
Address \_\_\_\_\_ Apt.# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code(+4 if known) \_\_\_\_\_  
Home Phone(\_\_\_\_) \_\_\_\_\_ Cell Phone(\_\_\_\_) \_\_\_\_\_  
\*\*E-mail address \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_  
Employer's Phone Number (\_\_\_\_) \_\_\_\_\_ Marital Status S M D W  
Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_

#### Emergency Contact Information

Emergency contact person (*other than your spouse*) \_\_\_\_\_  
Telephone number at Home (\_\_\_\_) \_\_\_\_\_ Work(\_\_\_\_) \_\_\_\_\_

#### Guarantor Information

Guarantor's Name \_\_\_\_\_  
Birth Date \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Guarantor's Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

#### Insurance Information

Name of Insured Party \_\_\_\_\_ Birth Date \_\_\_\_\_  
Insured Party's Social Security Number \_\_\_\_\_  
Insurance Carrier \_\_\_\_\_ Telephone Number \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Claims Address \_\_\_\_\_  
Coverage Information \_\_\_\_\_

#### PLEASE READ CAREFULLY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Chiropractic Plus will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Chiropractic Plus will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that all past, present, and future bills incurred at Chiropractic Plus are my responsibility for payment. In the event that my bill must be turned over to an attorney for collection, I understand that I am liable for the balance due plus interest at the current rate, reasonable attorney's fees, and court costs. I authorize the release of any medical information necessary to process my claims.

#### PAYMENT IS DUE AT THE TIME OF THE VISIT

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Driver's License Number \_\_\_\_\_ Expires \_\_\_\_\_  
Guarantor's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Guarantor's Driver's License Number \_\_\_\_\_ Expires \_\_\_\_\_

# CHIROPRACTIC PLUS

## Current Health Condition

Please briefly describe the reason for this appointment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did this problem begin? \_\_\_\_\_

Have you had this problem before? **Yes No**

When was the last episode? \_\_\_\_\_

Is the condition related to (circle one):

**Job Accident, Auto, Home Injury, Fall, Other**  
\_\_\_\_\_

Have you been evaluated or treated for this condition by any other doctor/provider? **Yes No**  
If "yes", please list each provider and the treatment received: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you still under the care of any of these providers? **Yes No** If "yes" whom? \_\_\_\_\_  
\_\_\_\_\_

**During the course of your current condition**, have you experienced or are you experiencing any of the following: (please check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Headache                | <input type="checkbox"/> Flushing of face        |
| <input type="checkbox"/> Neck Pain               | <input type="checkbox"/> Lights bother eyes      |
| <input type="checkbox"/> Back Pain               | <input type="checkbox"/> Spots in front of eyes  |
| <input type="checkbox"/> Stiffness               | <input type="checkbox"/> Fever/chills            |
| <input type="checkbox"/> Tension                 | <input type="checkbox"/> Night sweats            |
| <input type="checkbox"/> Trouble sleeping        | <input type="checkbox"/> Difficulty swallowing   |
| <input type="checkbox"/> Pins/Needles in arms    | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Pins/Needles in legs    | <input type="checkbox"/> Shortness of breath     |
| <input type="checkbox"/> Numbness                | <input type="checkbox"/> Difficulty breathing    |
| <input type="checkbox"/> Cold hands or feet      | <input type="checkbox"/> Heart Palpitations      |
| <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Burning on urination    |
| <input type="checkbox"/> Ringing in ears         | <input type="checkbox"/> Difficulty urinating    |
| <input type="checkbox"/> Pressure in head/neck   | <input type="checkbox"/> Blood in urine          |
| <input type="checkbox"/> "Head feels too heavy"  | <input type="checkbox"/> Blood in stool          |
| <input type="checkbox"/> Loss of bowel control   | <input type="checkbox"/> Constipation            |
| <input type="checkbox"/> Loss of bladder control | <input type="checkbox"/> Diarrhea                |
| <input type="checkbox"/> Loss of smell or taste  | <input type="checkbox"/> Stomach problems        |
| <input type="checkbox"/> Memory loss             | <input type="checkbox"/> Nosebleeds              |
| <input type="checkbox"/> Loss of balance         | <input type="checkbox"/> Frequent sore throats   |
| <input type="checkbox"/> Irritability            | <input type="checkbox"/> Hot/cold flashes        |
| <input type="checkbox"/> Nervousness             | <input type="checkbox"/> Cramps                  |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Female problems         |
| <input type="checkbox"/> Fatigue/Tiredness       | <input type="checkbox"/> Swelling anywhere       |

## Past Medical History

If you have had any of the following, please check the box and give a brief description:

- Surgery \_\_\_\_\_  
\_\_\_\_\_  
 Broken Bones \_\_\_\_\_  
\_\_\_\_\_  
 Hospitalization \_\_\_\_\_  
\_\_\_\_\_  
 Serious Diseases \_\_\_\_\_  
\_\_\_\_\_  
 Prior Accidents/Injuries (include dates) \_\_\_\_\_  
\_\_\_\_\_

Please provide us any other information you feel is related to your **present** condition:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all current medications, vitamins, supplements, or herbs you are currently using:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please list **any** allergies:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## Family History

Please list any members of your immediate family who have or had any of the following:

Musculoskeletal Disease \_\_\_\_\_  
Heart Disease \_\_\_\_\_  
Lung Disease \_\_\_\_\_  
Cancer \_\_\_\_\_  
Nervous Disorder \_\_\_\_\_  
Metabolic Disorder (thyroid, diabetes, etc.) \_\_\_\_\_  
\_\_\_\_\_  
Other \_\_\_\_\_

## Pain Rating Scale

Please rate your pain on a **scale from 1 to 10** in each of the following categories:

**Current** level of pain: \_\_\_\_\_ out of 10

**Average** level of pain: \_\_\_\_\_ out of 10

**Worst** level of pain: \_\_\_\_\_ out of 10

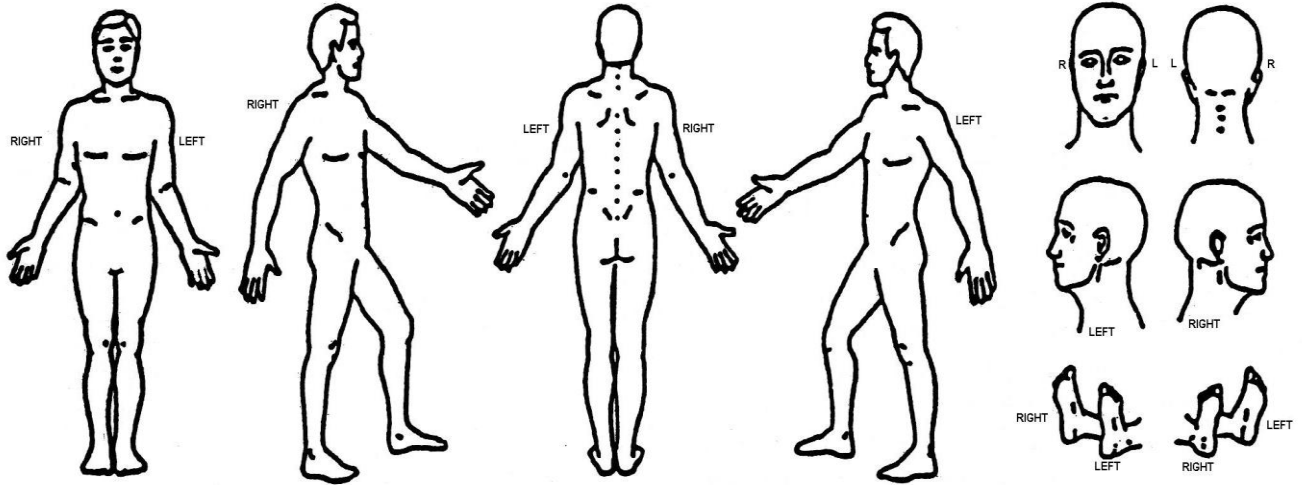
Name: \_\_\_\_\_ File # \_\_\_\_\_ Date \_\_\_\_\_

# CHIROPRACTIC PLUS

## Pain Assessment Tool

### 1. Location

Please mark the area(s) you are currently experiencing pain on the drawings below:



### 2. Quality

Using your own words, please describe the pain (i.e. ache, burn, sharp, dull, pulling, etc.)

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### 3. Onset, Duration, Variations, Rhythms

Describe how the pain begins, how long it lasts, whether it varies, and if it increases at certain times: \_\_\_\_\_

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### 4. What relieves the pain? \_\_\_\_\_

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### 5. What aggravates the pain? \_\_\_\_\_

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### 6. Describe any other factors associated with your pain: \_\_\_\_\_

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I certify that the information on all the forms is true and accurate to the best of my knowledge.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_