1 Patient Information

Name: ____
(First) (Initial) (Last) (Name called by)
Address: ____
____
(City) (State) (Zip Code)
Birthdate: __________ Age: ____ ☐Male ☐Female
Social Security # ______/_____/_____
Occupation: _____________________________________
Employer: _______________________________________
Parents Name(if a minor): ________________________
☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Spouse's Name: __________________________________
# of Children:___ Name(s)_________________________
How were you referred to Fixen Chiropractic?
☐Patient _______________ ☐ Physician ____________
☐Yellow Pages ☐Internet ☐Radio ☐Newspaper ☐Sign
☐Other ____

2 Insurance

Who is responsible for this account?____________
Relationship to patient________________________
Insurance company___________________________
Insurance ID number_________________________
Group / Claim number________________________
Is patient covered by additional insurance? ☐Yes ☐No
Insurance company___________________________
Subscriber # and name_______________________
Birthdate ___________ Group #______________

Please present insurance card(s) so we can put a copy in your file.

3 Accident Information

Is your condition due to an accident? ☐No ☐Yes
Date of accident: ___________
Type of accident? ☐Automobile ☐Work ☐Home ☐Other
To whom have you reported the accident?
☐Insurance ☐Worker's Comp ☐Employer ☐Other______
Attorney Name (If applicable)___________________

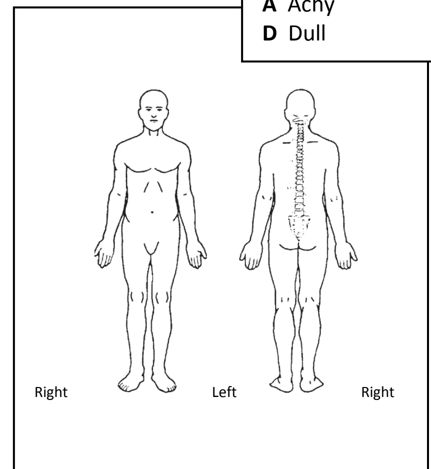
4 Contact Information

Home phone ________________________________
Cell phone _________________________________
Work Phone __________________ Ext ________
Email _____________________________________
Best way to reach you: ☐Home ☐Cell ☐Work ☐Email

IN CASE OF EMERGENCY, CONTACT:
Name _____________________________________
Relationship _______________________________
Home Phone ________________________________
Cell

5 Patient Condition

What is your major symptom/problem? ____________________________
When did your symptoms begin? _________________________________
Have you had this problem before? ______________________________
Is your condition getting progressively worse? ☐Yes ☐No
Is this problem: ☐constant ☐comes and goes
How does it Feel? ☐Burning ☐Sharp ☐Shooting ☐Dull ☐Aching ☐Stiff
Tingling ☐Throbbing ☐Swelling ☐Other____________________
Please mark the area(s) affected on the diagram to the right with the type of pain associated (see box at top right of diagram).
Circle below the severity of your pain on a scale of 0 to 10:
(No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe pain)
What makes your condition better? ____________________________
What makes your condition worse? ____________________________
Does it interfere with your ☐Work ☐Sleep ☐Daily ☐Routine ☐Recreation
Activities/movements that are painful to perform: ☐Sitting ☐Standing
Walking ☐Bending ☐Lying down ☐Driving ☐Reading ☐Getting Up



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Health History

What other treatments have you had for this condition?

☐Chiropractic ☐Orthopedic ☐Neurologist ☐Physical Therapy ☐Medication ☐Surgery

Name of other doctors who have treated you for this condition____

Describe the other doctor's treatment for your condition ____

Previous Chiropractic care? ☐No ☐Yes Date____________ ☐Local ☐Out of state _______________________

Date of Last: Physical Exam____________ Spinal x-ray____________ MRI ________________

Spinal Exam _____________ Dental x-ray____________ CT- Scan ____________

List any Medications you are taking ____

Vitamins / Herbs / Minerals ____

Females: Are you Pregnant ☐Yes ☐No Beginning of last menstrual cycle _____________________________

Check any of the following conditions you have had:

☐AIDS/HIV	☐Digestion problems	☐Insomnia	☐Sciatica
☐Allergies	☐Earache	☐Irregular cycle	☐Shingles
☐Anxiety/Depression	☐Ear ringing	☐Kidney problems	☐Sinus infection
☐Arm/shoulder pain	☐Epilepsy	☐Leg pain	☐Stroke
☐Arthritis	☐Gout	☐Low back pain	☐STD
☐Asthma	☐Headaches	☐Neck pain	☐Thyroid problem
☐Bladder problems	☐Headaches - Migraine	☐Osteoporosis	☐TMJ
☐Breast Lump	☐Heart Disease	☐Pace Maker	☐Vertigo/Dizziness
☐Cancer	☐Hemorrhoids	☐Pinched Nerve	
☐Chronic fatigue	☐Herniated disk	☐Poor circulation	
☐Deafness	☐High blood pressure	☐Prostate problems	
☐Diabetes	☐High Cholesterol	☐Rheumatoid Arthritis	

Stressors

☐ Smoking Packs/Day _________________

☐ Alcohol Drinks/Week _______________

☐ Coffee/Caffeine Drinks Cups/Day _________________

☐ High Stress Level Reason ___________________

Exercise

☐None

☐Moderate

☐Daily

☐Heavy

Have you had any:	**Description**	**Date**
Automobile accidents	________________________________	_____________
Surgeries	________________________________	_____________
Broken bones	________________________________	_____________
Falls/Head injuries	________________________________	_____________

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AUTHORIZATION

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Fixen Chiropractic/Quentin Fixen D.C. to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

_________________________________ _______________ ____________________________

Signature Date Parent (if patient is a minor)