Patient Information

Last Name: First Name: Middle Name:

Gender: Marital Status:

Street Address:

City: State: Zip:

Date of Birth:

SS#:

Best Contact Phone:

Work Phone: Cell:

Emergency Contact and #:

E-Mail:

*Your email will not be shared with any 3rd parties, and is used for occasional office communications.

Referred By:

- ☐ Patient Referral :____________________ ☐ Web Search ☐ Promotion
- ☐ Physician Referral:__________________ ☐ BC/BS Web ☐ Greer Chamber
- ☐ Employee Referral: ☐ Walk-In ☐ Phone Book

Current Health Conditions

Health related problem you are having today :

Onset Date: Has this condition occurred before: ☐ Yes ☐ No

Is condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other ☐ Unknown

Previous Chiropractic Care: ☐ None

☐ Doctor's Name and approx. date of last visit:

Insurance Information

Party responsible for payment ☐ Self ☐ Insurance ☐ Parent/Guardian

Health Insurance

Name of Health Insurance Company:

Auto Accident Insurance

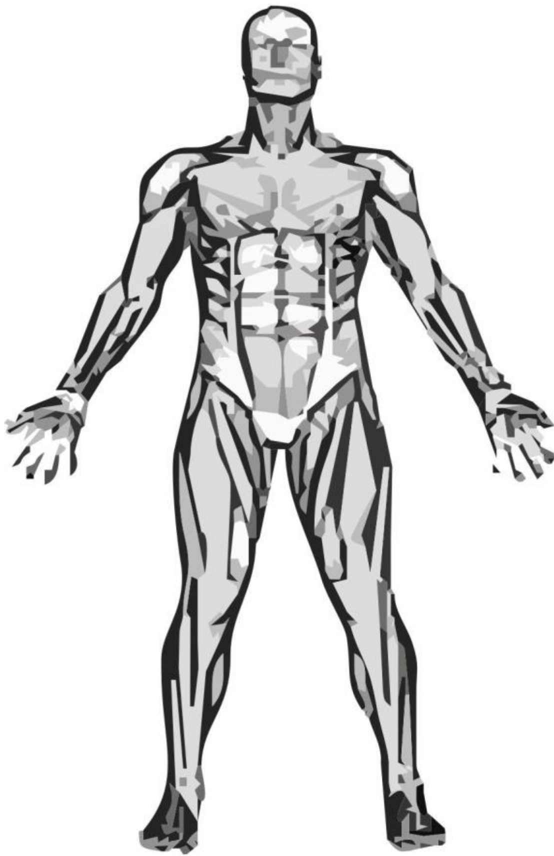
Name of Auto Insurance Company:

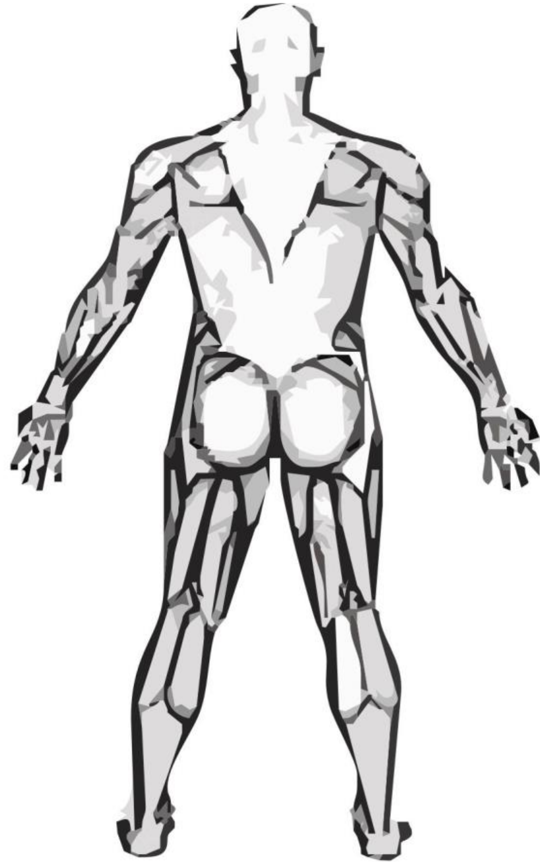
Phone Number: Contact Person"

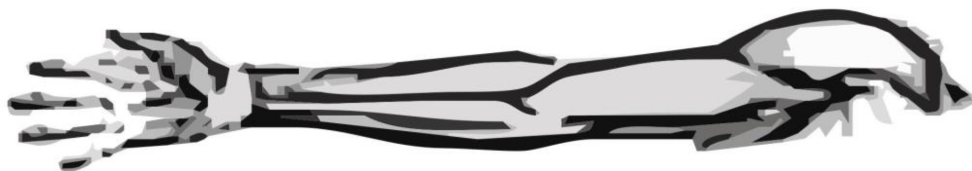
Claim Number:

Please use the following letters to indicate TYPE and
LOCATION of the symptoms you currently are experiencing

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing







Patient Signature ______________________________________ **Date** _____________________

REVIEW OF SYSTEMS (1)

Below is a list of symptoms that may seem unrelated to the purpose of today's appointment but must be answered carefully as these problems can affect your overall course of care.

Check	Diseases You Have Had:	Office Use Only (do not write in this area)
	Diabetes	
	Cancer	
	Heart Disease	
	Thyroid (Hyper/Hypo)	
	Eczema	
	Arthritis	
	HIV	
	Mental Disorders	
A.	**Musculo-Skeletal**	
	Low back Pain	
	Shoulder Pain	
	Neck Pain	
	Arm Pain	
	Joint Pain/Stiffness	
	Difficulty Walking	
B.	**Nervous System**	
	Nervous	
	Numbness	
	Paralysis	
	Dizziness or Fainting Spells	
	Forgetfulness	
	Stress	
	Seizures or Convulsions	
	Cold/Tingling Extremities	
C.	**Genitio-Urinary**	
	Bladder Trouble	
	Painful Urination	
	Discolored Urine	
D.	**C-V-R**	
	Chest Pain	
	Shortness of Breath	
	Difficulty Breathing When Lying Down	
	Blood Pressure (High/Low)	
	Irregular Heartbeat	
	Racing Heart	
	Stroke	
	Heart Problems	
	Congestion/Lung Problems	
	Emphysema	
	Coughing Spells	
	Coughing Blood	
	Varicose Veins	
	Swelling in Feet or Ankles	
	Pain in Leg After Walking	

Patient Signature ______________________________________ **Date** _____________________

REVIEW OF SYSTEMS (2)

Check		Office Use Only (do not write in this area)
E.	**EENT**	
	Headaches	
	Vision Problems (Blurred/Double/Glaucoma)	
	Dental Problems	
	Clicking Jaw/TMJ	
	Neck Lumps or Swelling	
	Sore Throat/Hoarseness	
	Difficulty Swallowing	
	Earaches	
	Hearing Problems	
	Stuffed Nose/Nose Bleeds	
	Allergies	
F.	**Gastro-Intestinal**	
	Poor/Excessive Appetite	
	Excessive Thirst	
	Frequent Nausea	
	Vomiting	
	Heartburn	
	Gas/Bloating	
	Diarrhea/Constipation	
	Hemorrhoids	
	Black/Bloody Stool	
	Liver Problems	
	Gall Bladder Problems	
	Weight Trouble	
	Abdominal Cramps/Colitis	
G.	**Female Gender Specific**	
	Menstrual Irregularity	
	Menstrual Cramps	
	Are You Pregnant? Yes ____ No____	
	Breast Pain/Lumps or Masses	
	Frequent Vaginal Infections	
H.	**Male Gender Specific**	
	Chronic or Recurrent Infections	
	Lumps or Masses in Penis or Testicles	
I.	**General Health**	
	Unexplained Weight Loss	
	History of Diabetes	
	Loss of Sleep	
	Fatigue	
	Fever	

The following family members have the same or similar problems as I do:________________

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Patient Signature ______________________________________ **Date** ________________________________