Friesen Chiropractic Clinic

Patient Information

How Did You Hear Of Our Clinic? ( )Phone Book Advertisement ( ) Insurance Company ( ) Internet ( ) Word Of Mouth ( ) Other _____

Name: _____ Date: ____/____/____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone: _____ Cell: _____
Date of Birth ____/____/____ Sex: _____ Marital Status: _____ SSN: _____

Employer: _____ Employer Address: _____
City: _____ State: _____ Zip Code: _____ Phone: _____
Name of Insured: _____ Relationship to Patient: ( )Spouse ( )Parent
Insurance Company: _____ Policy #: _____
Secondary Insurance: _____ Policy #: _____

Is This Injury The Result of Work or An Automobile Accident? ( )YES ( )NO Date of Injury: ____/____/____
Describe What Hurts: _____
What Activities Are Hard To Perform: _____
Describe Your Pain If You Are Having Any: _____
Circle the Severity of Your Pain: (1=Mild, 10= Severe) 1 2 3 4 5 6 7 8 9 10
Have You Had These Problems Before?: ( ) Yes ( ) No If So, When?: _____

Circle Those Conditions You Have Now, or Have Had Previously.

Musculosketelal	*GastroIntestinal*	*Eyes, Ears, Nose*	*Conditions*	*Conditions*
Arthritis	Colon Trouble	Asthma	Aids/HIV	Alcoholism
Bursitis	Constipation	Bronchitis	HBP or LBP	Appendicitis
Neck Pain	Diarrhea	Emphysema	Cancer	Diabetes
Mid Back Pain	Digestion	Earache	Eczema	Epilepsy
Low Back Pain	Gallbladder	Tinnitis	Gout	Mumps
Tail Bone Pain	Hemorrhoids	Eye Pain	Multiple Sclerosis	Polio
Shoulder/Arm	Stomach Pain	Nose Bleeds	Pneumonia	Rheumatic Fever
Leg Pain/Wknes	Vomiting	Sinus Infections	Stroke	Tuberculosis
Numbness			Venereal Dis.	Ulcer
Sciatica			Chest Pain	Kidney Stones

Are You Currently Taking Prescription Medication(s)? _____
Date of Your Last Medical Examination: ____/____/____.

Have You Ever Smoked?: ( ) Yes ( ) No. Do You Consume Alcohol on a Regular Basis?: ( ) Yes ( ) No.
Women Only: Are You Pregnant?: ( ) Yes ( ) No Date of Last Menses: ____/____/____

I CERTIFY THAT I HAVE READ AND UNDERSTOOD THE QUESTIONS LISTED ABOVE AND THAT I HAVE ANSWERED THOSE QUESTION TRUTHFULLY. I UNDERSTAND THAT INCORRECT INFORMATION COULD HAVE A NEGATIVE IMPACT UPON DIAGNOSIS, TREATMENT AND RECOVERY FORM ANY CONDITION I MAY CURRENTLY SUFFER FROM.

X: _____ ____/____/____
SIGNATURE OF PATIENT/GUARDIAN/PARENT TODAYS DATE