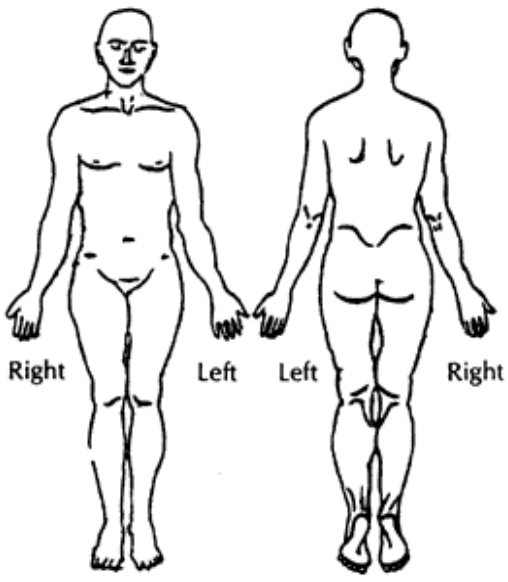
My Chiropractic Center
203 North Throop Street
Woodstock, IL. 60098

Date: _____/_____/_____

Patient Name: _____Age: _____ Date of Birth: _____
Address: _____ Home Phone _____
City: _____ State: _____ Zip: _____ Cell Phone _____
Marital Status: _____ Number of Children: _____ SS #: _____
E-mail: _____
Can we send you e-mail newsletters? YES _____ NO _____ Can we send you office updates? YES _____ NO _____
How did you hear about our office? _____
_____
_____
Employer: _____ Occupation: _____ Work Phone:_____
Employer Address: _____
City: _____ State: _____ Zip: _____ _____
Employment Status: Full Time __Part Time __Full Time Parent __Light Duty__ Heavy Duty__Off Due to Injury__ Retired__ Student__
Primary Method of Payment: Cash__ Debit Card __Credit Card __ Check__ Insurance__ Do you Have Insurance: YES____ NO_____
Insurance Provider: _____*ID#*_____Plan / Group # _____

If Insurance plan is through your spouse **OR** If you have secondary insurance through your spouse, please fill out the following:
Name of Spouse: _____ Spouses Date of Birth: _____
Spouses Insurance Provider: _____ Plan / Group # _____
Spouses Employer: _____ Spouses Occupation: _____
Employer Address: _____ Spouses Work Phone: _____
Describe your main complaint or reason for your visit: _____
_____
_____

Use the diagram to the right to show where your problem is located
Please use the line below to rate your level of discomfort today?
(*zero pain*) >1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10--- <(*worst pain*)
Is your problem a result of a work / auto related injury YES NO
Is someone else legally responsible for your injury YES NO
How serious is this problem? _____
When did this problem begin? _____
When does it bother you most? _____
Does anything else happen with this problem? _____
_____
_____
_____



List any previous hospitalizations: _____
_____
_____
List any previous surgeries: _____
_____
_____

Do you use tobacco products? YES NO If "yes" how often? _____
How often do you drink alcohol? YES NO If "yes" how often? _____
Do you drink TEA or COFFEE? YES NO If "yes" how often? _____
Do you drink caffeinated drinks / colas? YES NO If "yes" how often? _____
Do you take any Medications? YES NO If "yes" please list: _____
_____
Do you take any other drugs? YES NO If "yes" please list: _____
_____
Do you have ANY allergies? : YES NO If "yes" please list: _____
_____
Do you take any Supplements? YES NO If "yes" please list: _____
_____
How often do you drink water? _____ Do you buy bottled water? YES NO
Do you exercise? _____ Do you belong to a gym? YES NO

Please circle any of the problems listed below, which you may have or have had in the past year:

Fevers	Neck Pain	Painful Swallowing	Heart Palpitations	Vomiting	Nausea
Headaches	Rashes	Double Vision	Weakness	Dizziness	Back Pain
Night Pain	Numbness	Joint Swelling	Muscle Pains	Joint Pain	Chest Pain
Incontinence	Constipation	Depression	Shortness of Breath	Vision Problems	
Wheezing	Anxiety	Blurred Vision	Suicidal Thoughts	Uncontrolled Coughing	

Sweating under only 1 Arm - Urinary Urgency - Problems Urinating - Black/Bloody Stools - Loss of voluntary movement

Please list any Family health issues:

Grand Father: _____
Grand Mother: _____
Father: _____
Mother: _____
Brother: _____
Sister: _____
Children: _____
Children: _____
Children: _____
Children: _____

Consent to treat a minor:

I, _____, parent / legal guardian of _____, born on _____, do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my child while said child is under the care of _____ and I am not reasonably available by telephone to give consent. This authorization is effective from the date signed until terminated by the undersigned.

Date: ____/____/____ Signature: _____

Please sign:

I understand I am legally responsible for any charges which I may accrue, for my treatment at My Chiropractic Center. All of the information I have provided is legal and accurate to the best of my ability.

Date: ____/____/____ Signature: _____