Frontier Chiropractic and Imaging Center

Patient Information:

First Name ______________________________ **Last Name** _______________________________ **Date**______________

Address ______________________________ **City** _______________________ **State** ___________ **Zip Code** __________

Birth Date ____________ **Age** ________ **Referred By** ____

Home Phone ____________________ **Work Phone** ________________________ **Cell Phone** _______________________

Occupation _____________________________________ **Employer** ____

Marital Status __________ **Emergency Contact** ______________________ **Phone** ________________________________

Email Address ____ (this is only used for our monthly newsletters/specials)

Date your symptoms began: ___________ (mm/dd/yyyy)

Briefly describe your symptoms: ____

How did your symptoms start? ____

Average pain intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

How often do you experience your symptoms?

1 - Constantly (76% - 100% of the time) 2 - Frequently (51% - 75% of the time)

3 - Occasionally (26% - 50% of the time) 4 - Intermittently (0% - 25% of the time)

How much have your symptoms interfered with your daily activities?

1 - Not at all 2 - A little bit 3 – Moderately 4 - Quite a bit 5 - Extremely

In general, would you say your overall health right now is?

1 – Excellent 2 - Very good 3 – Good 4 - Fair 5 – Poor

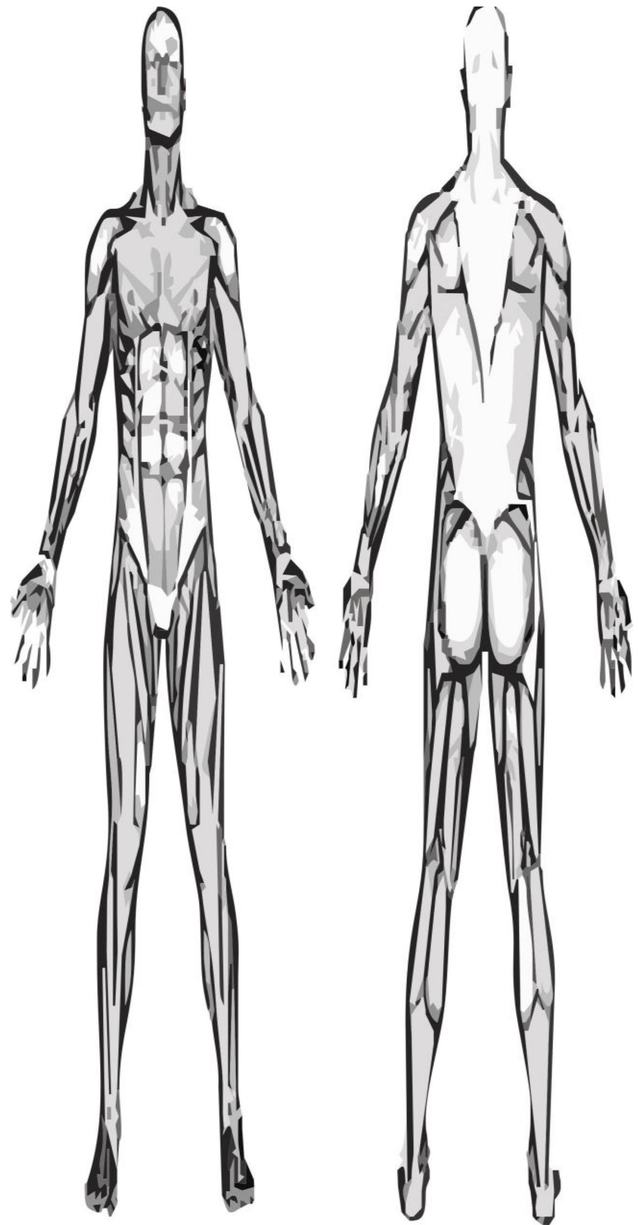
I agree that all the information provided above is accurate. I understand that health/accident insurance policies are an agreement between my insurance carrier and myself. I understand and agree that all service's rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fee for professional services rendered to me will be immediately due and payable.

Patient Signature ____ **Date** ___________________________

Please indicate on the models where you are having pain or other symptoms such as burning, numbness, pins and needles, stabbing or ache.

Have you ever suffered from:

- ❑ Alcoholism
- ❑ Allergies
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chest pain
- ❑ Constipation
- ❑ Cramps
- ❑ Depression
- ❑ Diabetes
- ❑ Digestion Problems
- ❑ Dizziness
- ❑ Eye Pain
- ❑ Fatigue
- ❑ Hemorrhoids
- ❑ High Blood Pressure
- ❑ Hot Flashes
- ❑ Irregular Heart Beat
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Loss of Memory
- ❑ Lumps in Breast
- ❑ Neck Pain of Stiffness
- ❑ Nervousness
- ❑ Pacemaker
- ❑ Poor Posture
- ❑ Prostate Trouble
- ❑ Sciatica
- ❑ Shortness of Breath
- ❑ Sleep Problems/Insomnia
- ❑ Spinal Curvatures
- ❑ Stroke
- ❑ Swelling of Ankles
- ❑ Swelling of Joints
- ❑ Thryroid Condition
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Other: __________



*Please note, all information filled out on this form is strictly confidential.

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