# Meridian Family Chiropractic


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CASE NO. ___________________

Please fill out the following form in as much detail as possible. Please print.

Date ___________________

Name ___________________________________________________________________

Address _________________________________________________________________

City ___________________________________ State _____________ Zip ________

Home Phone ____________________________ Office Phone __________________

Cell Phone (Other contact number) __________________________________________

E-mail Address (for notifications)_____________________________________________

Best way to notify you of appointments/reminders ________________________________

Age ___________ Date of Birth ______________________ Sex: (M) (F)

Social Security Number: __________________________________

How did you hear about us? ________________________________________________

Family Physician _______________________________ Phone # ___________________

Employer _____________________________________ Phone # __________________

Occupation ______________________________

Married ______ Partnered ______ Single ______ Widowed ______ Divorced ______

# of Children ________ Name of Spouse/Partner _____________________________

Have you ever had chiropractic care before? _____________________________________

For what problem? __________________________________________________________

Were the results satisfactory? Yes______ No_______ N/A_______

How will you pay for your appointment today?

_____ SELF PAY (Cash, Check, Credit card, Care Credit)

_____ Insurance (Please have insurance card available so we can make a copy)

Name of Insurance Company:_________________________________

Name of Person Insurance Policy is under: _______________________

If not self, Social Security Number of Individual: ________________________

Date of Birth of Individual: _________________

*Office Notes:*

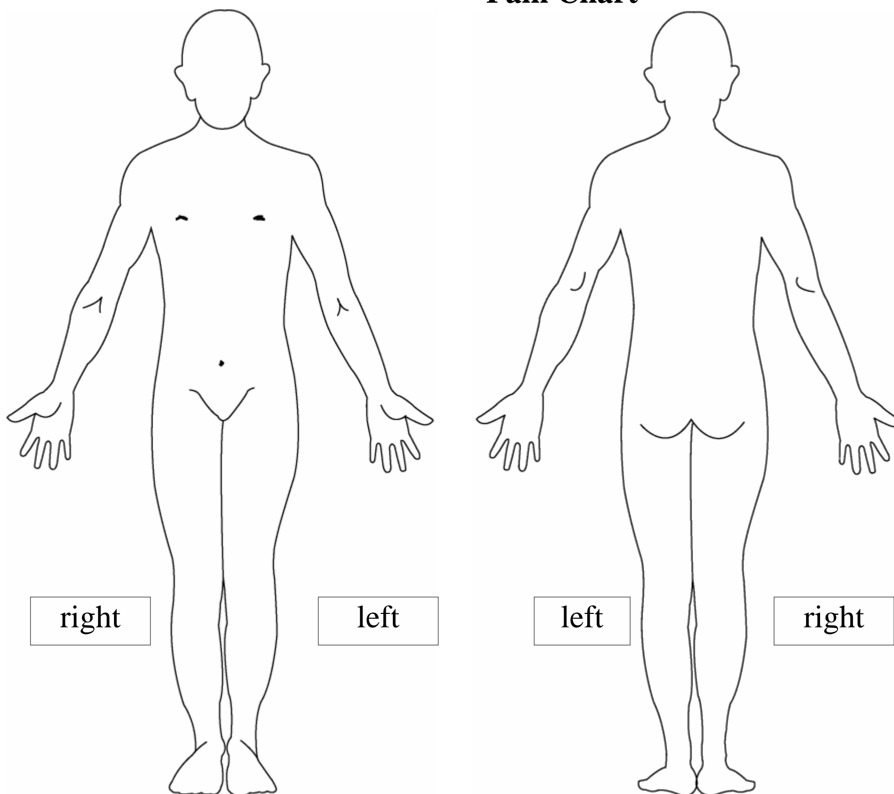
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation.
Include all affected areas.

| Numbness | Pins & Needles | Burning | Aching | Stabbing |
|---|---|---|---|---|
| - - - - - | 00000 | xxxxx | ***** | / / / / / |
| - - - - - | 00000 | xxxxx | ***** | / / / / / |
| - - - - - | 00000 | xxxxx | ***** | / / / / / |

Please mark on the pain scale from Zero to 10 the pain you feel with this condition.
10 being the worst pain you have felt with this condition.

## Pain Chart




**Neck-Shoulder-Arm-Pain**
On a scale of zero to 10, I rate my discomfort as follows:
**(____________________)**
**0 10**
**no pain severe pain**

**Mid Back Pain**
On a scale of zero to 10, I rate my discomfort as follows:
**(____________________)**
**0 10**
**no pain severe pain**

**Low Back and Leg Pain**
On a scale of zero to 10, I rate my discomfort as follows:
**(____________________)**
**0 10**
**no pain severe pain**

## Family History

Did you mother or father have any of the following:
Put an **M** for mother, **F** for father, and **B** for both.

( ) High Blood Pressure
( ) Heart Attack
( ) Emphysema
( ) Seizure-Convulsions
( ) HIV Positive
( ) Asthma
( ) Diabetes
( ) Ulcer or Stomach Problems
( ) Stroke (Please indicate age when stroke occurred,
Mother _______ Father _______ )
( ) Arthritis-Rheumatism
( ) Cancer
( ) Thyroid Disease
( ) Kidney Disease

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter **N** if you have these conditions now (within the past 12 months) or **P** if you ever had these conditions in the past.

| | Now N | Past P | | Now N | Past P |
|---|---|---|---|---|---|
| Headaches____ Frequency | ____ | ____ | Loss of Balance | ____ | ____ |
| Neck Pain | ____ | ____ | Fainting | ____ | ____ |
| Stiff Neck | ____ | ____ | Loss of Smell | ____ | ____ |
| Sleeping Problems | ____ | ____ | Loss of Taste | ____ | ____ |
| Back Pain | ____ | ____ | Diarrhea | ____ | ____ |
| Nervousness | ____ | ____ | Feet Cold | ____ | ____ |
| Tension | ____ | ____ | Hands Cold | ____ | ____ |
| Irritability | ____ | ____ | Arthritis | ____ | ____ |
| Chest Pains | ____ | ____ | Muscle Spasms | ____ | ____ |
| Dizziness | ____ | ____ | Frequent Colds | ____ | ____ |
| Shoulder/Neck/Arm Pain | ____ | ____ | Stomach Upset | ____ | ____ |
| Pins & Needles in Arms | ____ | ____ | Constipation | ____ | ____ |
| Pins & Needles in Legs | ____ | ____ | Cold Sweats | ____ | ____ |
| Numbness in Fingers | ____ | ____ | Fever | ____ | ____ |
| Numbness in Toes | ____ | ____ | Sinus Problems | ____ | ____ |
| High Blood Pressure | ____ | ____ | Diabetes | ____ | ____ |
| Difficulty Urinating | ____ | ____ | Hemorrhoids | ____ | ____ |
| Allergies | ____ | ____ | Leg Cramps | ____ | ____ |
| Weakness in Arms | ____ | ____ | Colitis | ____ | ____ |
| Weakness in Legs | ____ | ____ | Gall Bladder | ____ | ____ |
| Shortness of Breath | ____ | ____ | Indigestion | ____ | ____ |
| Fatigue | ____ | ____ | Belching | ____ | ____ |
| Depression | ____ | ____ | Vomiting | ____ | ____ |
| Lights Bother Eye | ____ | ____ | Shoulder Pain | ____ | ____ |
| Loss of Memory | ____ | ____ | Swelling Joints | ____ | ____ |
| Ears Ring | ____ | ____ | Knee Pain | ____ | ____ |
| Face Flushed | ____ | ____ | Hayfever | ____ | ____ |
| Buzzing in Ears | ____ | ____ | Menstrual Difficulties | ____ | ____ |

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered me are charges directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT SIGNATURE ________________________________________________

PATIENT NAME ______________________________________________________

DATE ____________

# PATIENT QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

| Name of Individual | | Relationship to Patient |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

1. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

   Name ___________________________ Phone #: _________________________

   Name ___________________________ Phone #: _________________________

2. Can we send mail addressed to you to your home mailing address:

   YES ________ No ________

3. Please mark if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

   YES ________ No ________

4. Can confidential messages be left on your telephone answering machine/voice mail?

   YES ________ No ________

5. Can we send you e-mails regarding your appointments (ie. appointment reminders)?

   YES ________ No ________

6. Do you give us permission to use your first name and last initial on our patient appreciation board?

   YES ________ No ________

7. Do you give us permission to use your photo on our patient appreciation board (will only be used inside our office)?

   YES ________ No ________

PATIENT
SIGNATURE: ________________________________________ DATE: ________________
(Guardian if patient is under 18 years of age)

**ACKNOWLEDGEMENT OF RECEIPT OF**
**NOTICE OF PRIVACY PRACTICES**

I, ______________________, [patient's name] acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Meridian Family Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

____________________ ______________________________________
Date Signature

______________________________________
Print Name