WAGNER CHIROPRACTIC

8333 Alexandria Pike Alexandria, Ky 41001

PH-859-448-0056 FAX-859-448-0156

PATIENT INFORMATION FORM

DATE:

PATIENT NAME

DATE OF BIRTH: AGE SEX

HOME ADDRESS

CITY STATE ZIP

HOME PHONE WORK PHONE: CELLPHONE

E-MAIL CAN WE LEAVE A MESSAGE? YES NO

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY?

IF YES, NAME

RELATIONSHIP PHONE

EMERGENCY CONTACT PHONE

PRIMARY CARE DOCTOR PHONE

WHO REFERRED YOU TO US?

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR CLINICAL INFORMATION?

NAME's

WHO IS RESPONSIBLE FOR PAYMENT?

RELATIONSHIP TO PATIENT

ADDRESS CITY

STATE ZIP PHONE

INSURANCE INFORMATION

ARE YOU ELIGIBLE FOR MEDICARE AND/OR MEDICAID? YES NO

PRIMARY INSURANCE COMPANY NAME

ADDRESS

CITY STATE ZIP PHONE

PATIENT NAME DATE OF BIRTH

INSURED NAME DATE OF BIRTH

INSURED NAME:

EMPLOYER

CONTRACT# GROUP#

SECONDARY INSURANCE COMPANY NAME:

ADDRESS

CITY STATE ZIP PHONE

INSURED NAME

DATE OF BIRTH

EMPLOYER

CONTRACT# GROUP#

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	How often do you take?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE

PLEASE LIST ALL **PRIOR** HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐

DIVORCED ☐ WIDOWED ☐

USE OF ALCOHOL: YES ☐ NO ☐

USE OF TOBACCO: YES ☐ NO ☐ QUIT-HOW LONG AGO?

USE OF RECREATIONAL DRUGS: YES ☐ NO ☐

If YES; TYPE	How often do you take?

HOW MUCH AREYOU ON YOUR FEET AT WORK? 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100% ☐

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ELDERLY ☐ DISABLED FAMILY MEMBER ☐

CHILDREN ☐ OTHER ☐ PET(S) ☐ WHAT KIND?

EXERCISE: DAILY ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐

SEVERALTIMES A WEEK

TYPES OF EXERCISE:

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF:

DIABETES ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ CANCER ☐

RHEUMATOID ARTHRITIS ☐ THYROID DISEASE ☐ CORONARY ARTERY DISEASE ☐

STROKE ☐ OTHER ☐

MEDICAL HISTORY

ALLERGIES

NONE KNOWN ☐ FOODS ☐ IDIONE ☐ SHELLFISH ☐ LATEX ☐ TAPE ☐

ANESTHESIA ☐ MEDICIATIONS ☐

HAVE YOU EVER HAD ANY OF THE FOLLOWINGS?

ACID REFLUX	☐	GOUT	☐	PNEUMONIA	☐
ANEMIA	☐	HEART Attack	☐	POLIO	☐
ARTHRITIS	☐	HEART DISEASE/FAILURE	☐	RHEUMATIC FEVER	☐
ASTHMA	☐	HEPATITIS	☐	SICKLE CELL DISEASE	☐
BACK TROUBLE	☐	HIV+/AIDS	☐	SKIN DISORDER	☐
BLADDER INFECTIONS	☐	HIGH BLOOD PRESSURE	☐	SLEEP APNEA	☐
ABNORMAL BLEEDING	☐	KIDNEY DISEASE	☐	STOMACH ULCERS	☐
BLOOD CLOTS	☐	LIVER DISEASE	☐	STROKE	☐
BLOOD TRANSFUSION	☐	Low BLOOD PRESSURE	☐	THYROID DISEASE	☐
BRONCHITIS/EMPHYSEMA	☐	MIGRAINE HEADACHES	☐	TUBERCULOSIS	☐
CANCER	☐	MITRAL VALVE PROLAPSE	☐	MIGRAINE HEADACHS	☐
DIABETES	☐	NEUROPATHY	☐		
FIBROMYALGIA	☐	OPEN SORES	☐		

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

HAVE YOU HAD THIS CONDITION IN THE PAST?

IF YES, WHEN?

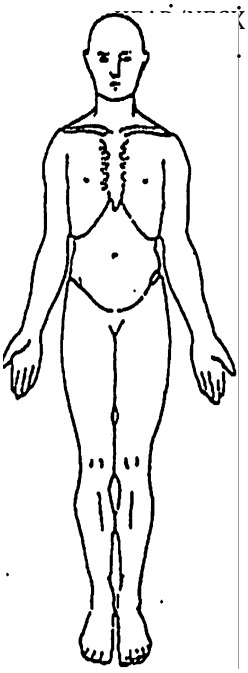
DID YOU SEEK TREATMENT BY A DOCTOR FOR THIS CONDITION?

IF YES, BY WHOM?

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

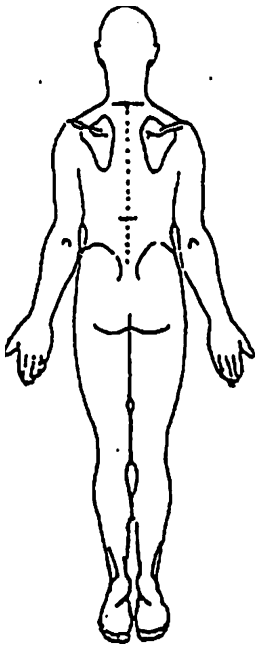
FRONT

HEAD/NECK/MIGRAINE ☐
SHOULDERS ☐
ARMS ☐
LOW BACK ☐
HANDS ☐
KNEES ☐
FEET ☐



BACK

HEAD/NECK/MIGRAINE ☐
SHOULDERS ☐
ARMS ☐
LOW BACK ☐
HANDS ☐
KNEES ☐
FEET ☐



How LONG AGO DID THIS PROBLEM FIRST START

DAYS ☐ WEEKS ☐ MONTHS ☐ YEARS ☐

DID YOUR PAIN OR PROBLEM?

BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME ☐

HOW WOULD YOU DESCRIBE YOUR PAIN?

SHARP ☐ DULL ☐ ACHING ☐ BURNING ☐ RADIATING ☐ ITCHING ☐

STABING ☐ OTHER ☐

HOW WOULD RATE YOUR PAIN FROM (0 TO 10)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT

STAYES THE SAME ☐ BECAME WORSE ☐ IMPROVED ☐

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE?

WALKING ☐ STANDING ☐ DAILY ACTIVITIES ☐ RESTING ☐ RUNNING ☐

OTHER ☐

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE AND ABILITY TO WORK?

WAS THIS PROBLEM CAUSED BY: INJURY ☐ AUTO ACCIDENT ☐

IF YES, DESCRIBE

WAS IT A WORK-RELATED INJURY? YES ☐ NO ☐

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY.

I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF

ANY CHANGES IN MY MEDICAL STATUS. YES ☐ NO ☐

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

SIGNATURE DATE

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Once completed, you can download the completed form, so you can send it as an attachment to:wchiro8333@gmail.com or print the file to bring in with you to your visit.

Print File