

# PEC Chiropractic

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Marital Status:  Married  Single  Divorced  Separated  Other \_\_\_\_\_

Name of Nearest Relative: \_\_\_\_\_ Phone: \_\_\_\_\_

Your Occupation \_\_\_\_\_ Your Employer: \_\_\_\_\_

Payment for Services will be by:  Cash  Check  Credit Card  Health Insurance  
 Automobile Insurance  Worker's Compensation

Name of Insurance Co.: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_ Employer's Phone #: \_\_\_\_\_

Are you covered by more than one insurance company?  Yes  No Name \_\_\_\_\_

**MEDICAL/FAMILY HISTORY (S = Self, M = Mother, F = Father)**

*indicate conditions in your family by marking boxes*

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	venereal disease

Have you been treated by a physician for any health condition in the last year?  Yes  No

Describe Condition \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_

SURGICAL HISTORY: (procedure and date) \_\_\_\_\_

Have you ever had a metal implant?  Yes  No Ever been gunshot?  Yes  No

**DESCRIBE PRESENT SYMPTOMS AND RATE ACCORDING TO PAIN SCALE**

SYMPTOM:	RATING
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

***Please fill out entire page completely***

*PEC Chiropractic*

**SYMPTOMS ARE WORST IN**   MORNING   AFTERNOON   NIGHT

**SYMPTOMS DEVELOPED FROM:**   JOB RELATED INJURY   AUTO ACCIDENT  
OTHER   ACCIDENT   ILLNESS   UNKNOWN CAUSE   GRADUAL ONSET

**DATE OCCURRED:** \_\_\_\_\_

**SYMPTOMS HAVE PERSISTED FOR HOW LONG?** \_\_\_\_\_

**SYMPTOMS/COMPLAINTS:**   COME & GO   ARE CONSTANT

**HAVE YOU EVER HAD THIS BEFORE:**   NO   YES   WHEN? \_\_\_\_\_

**IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?**  
\_\_\_\_\_

**NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):**  
\_\_\_\_\_

**ARE YOU ALLERGIC TO ANY MEDICATIONS**   NO   YES   WHAT KIND? \_\_\_\_\_

**ARE YOU TAKING ANY MEDICATIONS**   NO   YES   WHAT KIND? \_\_\_\_\_

**ARE YOU PREGNANT**   NO   YES   DATE OF LAST PERIOD \_\_\_\_\_

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:**  
BENDING   REACHING   STRAINING AT STOOL   COUGHING   SITTING   TURNING HEAD  
LIFTING   SNEEZING   WALKING   LYING DOWN   STANDING

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:**  
BENDING   SITTING   LIFTING   STANDING   LYING DOWN   TURNING HEAD  
REACHING   WALKING

**PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:**  
blurred vision   buzzing in ears   cold feet   cold hands   cold sweats   stomach upset  
concentration loss /confusion   constipation   depression /weeping spells   diarrhea  
dizziness   face flushed   fainting   fatigue   fever   head seems too heavy   headaches  
insomnia   light bothers eyes   loss of balance   loss of smell   loss of taste   stiff neck  
low resistance to colds   muscle jerking   numbness in fingers   numbness in toes  
pins and needles in arms   pins and needles in legs   ringing in ears   shortness of breath

**POLICY:** Fees are due and payable at the time of services rendered unless other arrangements have been made in advance. We reserve the right to demand payment at any time after services are rendered, regardless of any third party payor. All insurance companies are billed as a courtesy to our patients only, and all patients remain personally responsible for the total balance of their account. If this office is forced to take action to collect an outstanding balance, the patient will be held responsible for payment of all collection fees and costs. We reserve the right to charge \$30.00 for any missed appointment unless 24 hours advance notice is given. All original documents and x-ray films are and will remain sole property of this clinic. Copies are available upon request; requesting party must pay the applicable fees for copying.

By my signature below, I attest that all information is truthful and correct to the best of my knowledge. I have read, do understand, and do agree to honor the policies as stated above.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***Please fill out entire page completely***