# *Zygmont Chiropractic Center*

*Office use only*
Today's Date: ___________________________ *Patient #:* ______________

**Please Print**

## Patient Information

**Full Name:** __________________________________ **S.S.#:** ____________________ **Birth date:** _________
**Address:** _______________________________**City:** _____________**State:** _______ **Zip code:** ___________
**Home Phone:** _______________**Cell Phone:** _______________ **E-mail Address**_________________________
**Employer** _____________________________________ **Employer Phone:**________________________________
**Sex:** ☐ **Male** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Other**
☐ **Female**
**Driver's License No.** _______________________________ **State** ________
**In case of emergency,**
**Please contact:** __________________**Relationship:** ____________ **Phone#:** ______________
**Who may we thank for your referral?** ☐ **Yellow Pages** ☐ **Insurance Provider List** ☐ **Radio Ad**
☐ **Internet (please specify (i.e., Online Yellow Pages, Insurance Provider List, &etc.)**______________________
☐ **Friend (*Friend's Name:* ___________________)** ☐ **Other**_________________________

## Insurance Information

**Insurance Company:** _____________________________________ *(circle one)* **HMO PPO EPO POS**
**Phone No.:** _____________________________________________
**Insured Name:** ______________________________ **Birth Date:** _____________________________________
**Address:** ___________________________**City:** __________________**State:** __________**Zip code:** ________
**Insured ID:** _________________________________ **Group No.:** ______________________________________
**Employer:** _______________________________ **Address:** __________________________________________
**Work Phone:** ________________________________ **Home Phone:** ___________________________________

## Patient's Current Chief Complaint

**List your chief complaints and/or symptoms:** __________________________________________________
**Explain *WHEN* your health concern occurred:** _________________________________________________
**Symptoms developed from:** ☐ **Work related injury** ☐**Auto accident** ☐ **Injury other than work/auto**
☐ **Illness** ☐ **Gradual onset** ☐ **Unknown causes**

**Symptoms and/or complaints:** ☐ **come and go** ☐**are constant** ☐**came over time** ☐**came on quickly**

**Symptoms have persisted for:** ☐**hours** ☐ **one day** ☐ **weeks** ☐**months** ☐ **years**

**Symptoms are *better* in:** ☐ **morning** ☐ **noon** ☐ **night**
**Symptoms are *worse* in:** ☐ **morning** ☐ **noon** ☐ **night**

**Symptoms do not change with the time of day:** ☐ **yes** ☐ **no**

**Describe complaints in detail involving the following:**

**Head and Neck:** ______________________________

**Mid Back/Shoulders/Arms & Hands:** ______________________________

**Low Back/Hips/Legs & Feet:** ______________________________

**What activity makes condition *WORSE?*** ______________________________

**What activity makes condition *BETTER?*** ______________________________

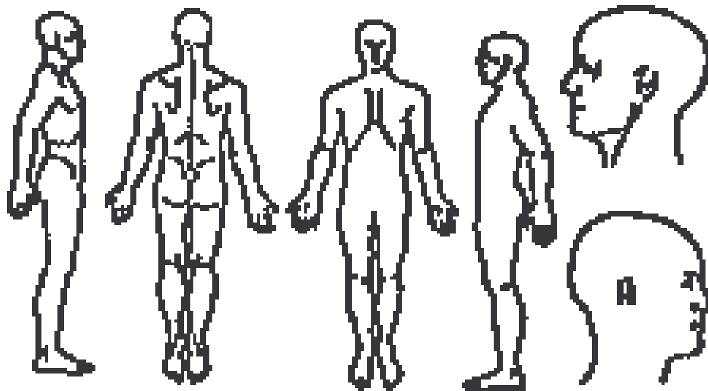
**Have you ever had this condition before?** ☐ **Yes** ☐ **no**

**If yes, when?** ______________________________

**Give name(s) and address(es) of doctor(s) previously seen for this condition:**

______________________________

**Shade area(s) to indicate location of pain or other symptoms:**



## Patient Medical History

**Do you have or have you ever been treated for** *(check all that apply)*

| | | | | |
|---|---|---|---|---|
| ☐ Stroke | ☐ heart attack | ☐ high blood pressure | ☐ phlebitis | ☐ hepatitis |
| ☐ Diabetes | ☐ heart condition | ☐ poor circulation | ☐ headaches | ☐ lyme's disease |
| ☐ Anemia | ☐ liver disease | ☐ osteoporosis | ☐ arthritis | ☐ Alzheimer's |
| ☐ Gout | ☐ rheumatic fever | ☐ keloid/thick scar | ☐ sciatica | ☐ asthma |
| ☐ Epilepsy | ☐ HIV/AIDS | ☐ nerve disorder | ☐ glaucoma | ☐ thyroid disease |
| ☐ Cancer | ☐ kidney disease | ☐ lung disease | ☐ tuberculosis | |
| ☐ Ear disorder | ☐ psychiatric disorder | ☐ stomach ulcer | ☐ vascular disease | |

☐ **Other(s):** ______________________________

**Do you have vascular grafts?** ☐ **yes** ☐ **no If yes, explain:**______________________________

**Do you have joint implants?** ☐ **yes** ☐ **no If yes, explain:**______________________________

**Do you have replacement heart valves?** ☐ **yes** ☐ **no If yes, explain:** ______________________________

**Are you under active chemotherapy?** ☐ **yes** ☐ **no If yes, explain:** ______________________________

**Have you had any other serious illness?** ☐ **yes** ☐ **no If yes, explain:**______________________________

**Have you had any surgery?** ☐ **yes** ☐ **no If yes, explain:**______________________________

**Have you ever been hospitalized or under medical care for over 24 hours?** ☐ **yes** ☐ **no**

**If yes, explain:**______________________________

**Any abnormal bleeding, or scaring?** ☐ **yes** ☐ **no If yes, explain:** ______________________________

**Are you slow to heal after a cut?** ☐ **yes** ☐ **no**

**No. of child births** ________________ **Are you pregnant?** ☐ **yes** ☐ **no**

**Do you smoke now or in the past?** ☐ **yes** ☐ **no If yes, packs/day** ________ **and how many years** ________**quit date** ________

**Alcoholic Beverages?** *(circle one)* **none rarely moderately daily quit**
**Recreational Drugs?** *(circle one)* **none rarely moderately daily quit**

**Please check items you use:** ⌑ **coffee** ⌑ **tea** ⌑ **sugar** ⌑ **artificial sweeteners** ⌑ **water** ⌑ **aspirin/Tylenol**
**List all medications you are currently taking** *(include prescription, over-the-counter, vitamins, herbs, and supplements):*
______________________________________________________________________________

**List any major diseases or health problems in your FAMILY:**

**Mother** ________________________________ **Father** ________________________________

**Siblings** ________________________________ **Other Relatives** ____________________________

**Have you consulted a Chiropractor in the past?** ⌑ **yes** ⌑ **no** **If yes, doctor's name, date and condition:**
______________________________________________________________________________

**Have you ever been in an auto accident? ?** ⌑ **yes** ⌑ **no** **If yes, when?** ________________________________

## Patient Financial Information and Agreement

**How will you compensate us for Chiropractic services?** ⌑ **Self Pay** ⌑ **Health Insurance** ⌑ **Auto Insurance** ⌑ **Worker's Compensation**

**Fees are payable at the time services are rendered, unless other arrangements are made in advance. You will be responsible for non-covered services, deductibles and co-pays. X-rays remain the property of this clinic for seven years. I instruct the insurance company to pay the doctor directly, and I authorize release of information to my insurance company.**

________________________________ ________________________
**Patient's Signature** **Date**

**I release any records to my attorney or parties involved in any work related or auto accident**

________________________________ ________________________
**Patient's Signature** **Date**