About You

Today's Date: _____/_____/_____

Patient Name: _____
LAST FIRST MI

What you prefer to be called: _____

Birthday: _____/_____/_____ Age: _____ ☐Female ☐Male

Address: _____

_____
CITY STATE ZIP

Home Phone: (_____) _____

Cell Phone: (_____) _____

Work Phone: (_____) _____ Ext_____

Email Address: _____

Referred By: _____

Marital Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed

Spouse's Name: _____

Do you have children? ☐Yes ☐No How many? _____

Employer: _____Occupation:_____

Injuries and Surgeries

Have you had any falls, accidents, or injuries?
☐Yes ☐No If so, please explain:

Month/Year	Type of Accident	Describe Injury

Have you had any surgeries?
☐Yes ☐No If so, please explain:

Month/Year	Type of Surgery	Why was surgery performed?

Reason For Your Visit

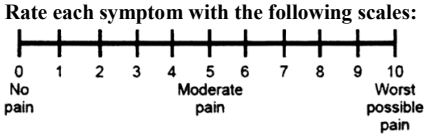
Reason for today's visit: ☐Emergency ☐New Injury ☐Old Injury ☐Chronic Pain ☐Wellness

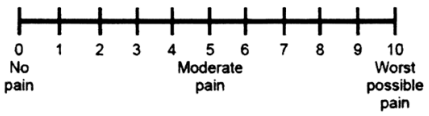
Symptom 1:_____
_____
_____

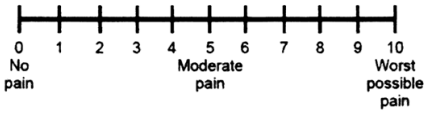
Symptom 2:_____
_____
_____

Symptom 3:_____
_____
_____

Rate each symptom with the following scales:







Have you consulted a chiropractor before? ☐No ☐Yes

If so: When? _____Where?_____

Did your injury occur during: ☐Work ☐Sports/Play ☐Auto Accident ☐Routine/Household Activity

When did your condition/accident occur? _____/_____/_____

Where did your injury occur? _____

Please explain what happened: _____

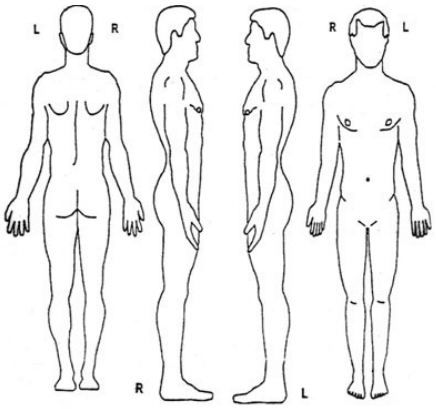
Is your condition getting worse? ☐Yes ☐No ☐Constant ☐Comes and Goes

Is your condition interfering with your: ☐Work ☐Sleep ☐Daily routine

If so, how: _____

Has this or something similar happened in the past? ☐Yes ☐No

Explain: _____ →



Using the adjacent body charts, please circle all affected areas.

Quality of symptoms (What does it feel like?):

☐Numbness ☐Tingling ☐Stiffness ☐Dull ☐Aching ☐Cramps
☐Nagging ☐Sharp ☐Burning ☐Shooting ☐Throbbing ☐Stabbing
☐Other _____

In Event Of Emergency

Whom should we contact? _____
Relation: _____
Home Phone #: (_____)_____
Work Phone #: (_____)_____
Cell Phone #: (_____)_____

Insurance Information

Primary Insurance:

Co. Name: _____
Address:_____
Phone#: (_____)_____
Insured's Identification #:_____
Group #:_____
Insured's Name: _____
Relation: _____Date of Birth: _____
Insured's Employer: _____

Initials _____ I acknowledge that any insurance I may have is an agreemen between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Medical History

Have you been treated by a Medical Physician for this condition? ☐Yes ☐No
Clinic or Dr's name: _____
Clinic Phone #: (_____)_____
Initials____ As a professional courtesy, I authorize Rauch Chiropractic to provide my medical doctor with a report for my medical record.

Do you have any of the following diseases, medical conditions, or procedures? **Circle those that apply:**

Heart Attack/Stroke	Fainting/Seizures
Artificial Valves	Chemotherapy
Shingles	Neck Pain
High/Low Blood Pressure	Lower Back Pain
Ulcers/Colitis	Middle Back Pain
Difficulty Breathing	Arthritis
Heart Surgery	Sinus Problems
Alcohol/Drug Abuse	Headaches
Cancer	Emphysema/Asthma
Heart Murmur	Artificial Bones/Joints
Pacemaker	Cochlear Implant
Insulin Pump	Hearing Aids

Other _____

Are you taking any medications? If so, please list:
_____
_____

To set clear expectations, improve communications and help you get the best results, please read each statement and initial your agreement.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge, I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office and understand that my signature is visible on the daily sign in sheet, referral board, and/or newsletter. We do not release this information to third parties.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Initials _____ CONSENT TO CARE FOR A MINOR: I hereby authorize Rauch Chiropractic to administer care as deemed necessary. If the patient is a minor Child, print child's full name:_____

Signature_____ Date _____
☐Adult Patient ☐Parent or Guardian ☐Spouse

Date:

Analysis

Doctor's Use Only, Please.

BP /

PULSE

HT

WT

SMOKER

RACE

ALLERGIES

MEDS

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