## Patient Information

**Today's Date** / / **Patient Title:** *(check one)* ❑ Mr.❑ Mrs.❑ Ms.❑ Miss❑ Dr.❑ Prof.❑ Rev.

**First Name**_____ **Nick Name**_____

**Last Name** _____ **Middle Name** _____**Suffix** _____

**Parents Name (if minor)** _____

**Address 1** _____

**Address 2** _____

**City**_____ **State**_____ **Zip Code** _____

**Primary Phone** _____**Secondary Phone** _____

**Mobile Phone** _____

**Home email** _____ **Work Email** _____

*By providing my email address, I authorize my doctor to contact me via the email address(es) provided.*

**Which email address would you like us to use to communicate with you?** *(check one)* ❑ Home ❑ Work

**Contact Method** *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

**Date of Birth** / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

**Social Security Number** - - **Marital Status** *(check one)*❑ Single ❑ Married ❑ Other

**Employment Status** *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

**What is your current occupation?** _____

**Race** *(check one)*

| | | | |
|---|---|---|---|
| ❑ White | ❑ Black/African American | ❑ Hispanic | ❑ American Indian/Alaskan Native |
| ❑ Asian | ❑ Asian Indian | ❑ Chinese | ❑ Filipino |
| ❑ Japanese | ❑ Korean | ❑ Vietnamese | ❑ Native Hawaiian or other Pacific Island |
| ❑Samoan | ❑ Guamanian or Chamorro | ❑Other_____ | ❑ I choose not to specify |

**Multi-Racial** *(check one)* ❑Yes ❑No ❑ Unknown

**Ethnicity** *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

**Preferred Language** *(check one)*

| | | | | | |
|---|---|---|---|---|---|
| ❑ English | ❑ Spanish | ❑ American Sign Language | ❑ Chinese | ❑ French | ❑ German |
| ❑ Tagalog | ❑ Vietnamese | ❑ Italian | ❑ Korean | ❑ Russian | ❑ Polish |
| ❑ Arabic | ❑ Portuguese | ❑ Japanese | ❑ French Creole | ❑ Greek | ❑ Hindi |
| ❑ Persian | ❑ Urdu | ❑ Gujarati | ❑ Armenian | ❑ I choose not to specify | |



Continued …

**Verification Question** so that we can talk to you about your health records if you call.

*(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

**Verification Answer to the Chosen question:** _____
*Answers must be at least 6 characters.*

## Patient Health History

**Do you currently smoke tobacco of any kind?** ❑ Yes ❑ Former smoker ❑ Never been a smoker

***If yes, how often do you smoke:*** ❑ Current every day smoker ❑ Current sometimes smoker

***If yes, what is your level of interest in quitting smoking?***

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
*No interest* *Very Interested*

**Current medications**, including frequency and dosage if known.
If there are no current medications, check here: ❑

| | | Start Date | | | Start Date |
|---|---|---|---|---|---|
| **1)** | | | **5)** | | |
| **2)** | | | **6)** | | |
| **3)** | | | **7)** | | |
| **4)** | | | **8)** | | |

**List any known allergies you have, medications or otherwise. If no allergies are known, check here: ❑**

**1)** _____ **3)** _____

**2)** _____ **4)** _____

**Briefly list your main health problems:** _____

_____

**Has any doctor diagnosed you with Hypertension presently?** ❑ Yes ❑ No If yes, describe: _____

_____

**Has any doctor diagnosed you with Diabetes presently?** ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

***If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?*** ❑ Yes ❑ No ❑ Not Sure

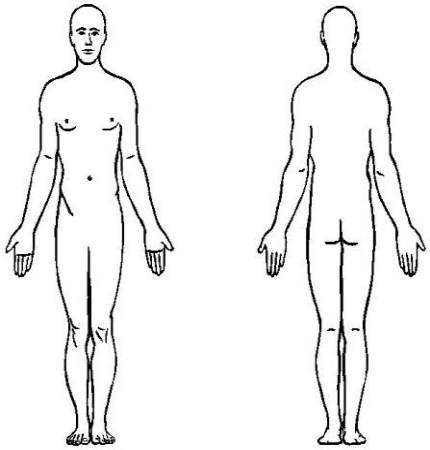
***If yes, other comments regarding Diabetes:*** _____

**Has any doctor diagnosed you with Cancer presently?** ❑ Yes❑ No If yes, what kind? _____


Continued …

**Current Condition(s)**

**Please indicate where you pain in on the picture with an X.**



Please list the current reason for your visit. _____

_____

How did the injury happen? _____

_____

When did your symptoms start? _____ days/ weeks/ months/ years ago

How often do you have this pain? _____

Is your pain constant or does it come and go? _____

What time of day are your symptoms worse? _____

What time of day are your symptoms better? _____

Please mark the severity of your pain on this scale:

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

*No Pain* *Severe Pain*

**Type of Pain: Circle**

| | | | | | |
|---|---|---|---|---|---|
| Dull | Sharp | Throbbing | Burning | Deep | Aching |
| Stabbing | Cramping | Numbness | Tingling | Radiating | Stiffness |

**Things that aggravate you symptoms: Circle**

| | | | | | |
|---|---|---|---|---|---|
| Sitting | Standing | Walking | Bending | Stooping | Lifting |
| Sleeping | Sneezing | Coughing | Straining | Reaching | Twisting |
| Looking Up | Looking Down | Movement | Rest | Lying Face-Up | Driving |
| Typing | Scooping | House Chores | Exercise | Lying Face-Down | Stair Stepping |

**Things that improve your symptoms: Circle**

| | | | | |
|---|---|---|---|---|
| Sitting | Standing | Lying | Knees Bent Up | Support |
| No Movement | Movement | Heat | Ice | Analgesic Topical |
| Ibuprofen | Medication | Rest | Stretching/ Exercise | Adjustment |

**What Activities that your symptoms interfere with: Circle**

| | | | | |
|---|---|---|---|---|
| Sleeping | Sitting | Standing | Lying down. | Walking |
| Exercise | Work | Recreation | House Work | Playing with Children |
| Running | Lifting | Driving | Riding in a car | Bending over |



Continued …

Have you ever been treated by a Chiropractor for any condition? ❑ Yes ❑ No When/Where _____

Have you had an X-ray or CT scan or MRI of your neck, mid back or lower back spine in the past 6 months?

❑ Yes ❑ No When and Where _____

What treatment have you already received for your condition? ❑Medical ❑Surgery ❑ Physical Therapy

❑Chiropractic Services ❑None ❑Other _____

Name and address of other doctor(s) who have treated you for your condition. _____

**Injuries / Surgeries / Broken Bones you have had: Description Dates**

Broken Bones _____

Car Wrecks _____

Falls _____

Head Injuries _____

Surgeries _____

Amount of **exercise** you get: ❑None ❑Very Little ❑ Daily ❑Moderate ❑Heavy ❑Vigorous

Amount of **alcohol** you consume: _____ drinks/week

Amount of **Coffee/ Caffeine** drinks you consume: _____ cups/day

**Stress Level** ❑None ❑Very Little ❑Moderate ❑High Reason: _____

## Insurance Information

***Please provide us with a copy of all your insurance cards***

**Who is responsible for this account?** ❑Self ❑Other _____ Relationship to patient _____

**Insurance Co.** _____ ❑ No Insurance

**Subscribers Name** _____ **Relationship to patient** _____

**Insurance ID Number** _____ **Insurance Group Number** _____

**I assign all insurance benefits, if any, to Dr. Steven Dryer. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.**
**Dryer Chiropractic may use my health care information and may disclose such information to the above named insurance company(ies) and their agent for the purpose of obtaining payment for related services. This consent ends when all bills are paid, treatment plan is completed, or one year after date signed.**

I consent to treatment by provided by Dryer Chiropractic for myself or for my child if he/she is a minor patient.

**Signature of Patient** ***(Parent if patient is a minor)***_____

Vitals: By clinic Staff: Ht. _____ inches Wt. _____ pounds BP _____/_____ Pulse _____