# Jeffrey P. Phillips Chiropractic, Inc.

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Woodland, CA 95695
(530) 666-2526

OFFICE USE ONLY
PATIENT # _____
DATE _____

## CONFIDENTIAL PATIENT INFORMATION

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of this form. If you need any help, please ask the receptionist.

### PATIENT DATA

(First name, middle initial, last name) **SOCIAL SECURITY #** _____ **DRIVER'S LICENSE #** _____

**NAME** _____

**EMAIL** _____ **HOME PHONE** _____ **CELL PHONE** _____

**HOME ADDRESS** _____ **CITY** _____ **ZIP CODE** _____

**MAILING ADDRESS** _____ **CITY** _____ **ZIP CODE** _____

**AGE** _____ **BIRTHDATE** _____ **MARITAL:** M S W D **HOW MANY CHILDREN?** _____

**OCCUPATION** _____ **EMPLOYER** _____

**EMPLOYERS' ADDRESS** _____ **OFFICE PHONE** _____

**NAME OF SPOUSE OR PARENT (circle one)** _____ **OCCUPATION** _____

**SPOUSE OR PARENTS' EMPLOYER** _____ **OFFICE PHONE** _____

**PATIENT'S NEAREST RELATIVE (other than spouse)** _____ **PHONE** _____

**RELATIVE'S ADDRESS** _____ **CITY** _____ **ZIP CODE** _____

**HOW WERE YOU REFERRED TO OUR OFFICE?** _____

**DATE OF LAST PHYSICAL EXAM** _____

**WHAT OPERATIONS HAVE YOU HAD & WHEN?** _____

**SERIOUS ILLNESSES** _____

**WHAT MEDICATIONS OR DRUGS ARE YOU TAKING?** _____

**WOMEN: ARE YOU PREGNANT?** ☐ **YES** ☐ **NO**

### INSURANCE DATA:

Name of person (s) responsible for payment _____

Do you have Insurance? ☐ No ☐ Yes Company's Name _____

Please list all sources of insurance:

- Group Insurance _____ (Name) EMPLOYEE I.D. NO. _____
- Spouse's Insurance _____ (Name) POLICY NO. _____
- Workmen's Compensation _____ (Name) GROUP NO. _____
- Others _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date: _____

Guardian or Spouse's Signature Authorizing Care _____ Date: _____

Information Taken By: _____ Date: _____

— PLEASE COMPLETE THE INFORMATION ON THE REVERSE SIDE ALSO —

**HEALTH QUESTIONAIRRE:** CHECK ANY OF THE FOLLOWING SYMPTOMS YOU ARE PRESENTLY HAVING

**SYMPTOMS:**

HEAD:
- ❑ Headache
  - ❑ entire head
  - ❑ back of head
  - ❑ forehead
  - ❑ temples
  - ❑ migraine
- ❑ Loss of balance
- ❑ Dizziness
- ❑ Ringing in ears

NECK:
- ❑ Stiff neck
- ❑ Muscle spasms in neck
- ❑ Grinding sounds in neck
- ❑ Pain in neck
- ❑ Neck pain with movement

SHOULDERS:
- ❑ Pain in shoulder joint (R-L)
- ❑ Pain across shoulders
- ❑ Bursitis (R-L)
- ❑ Arthritis (R-L)
- ❑ Can't raise arm
  - ❑ above shoulder level
  - ❑ over head
- ❑ Tension in shoulders

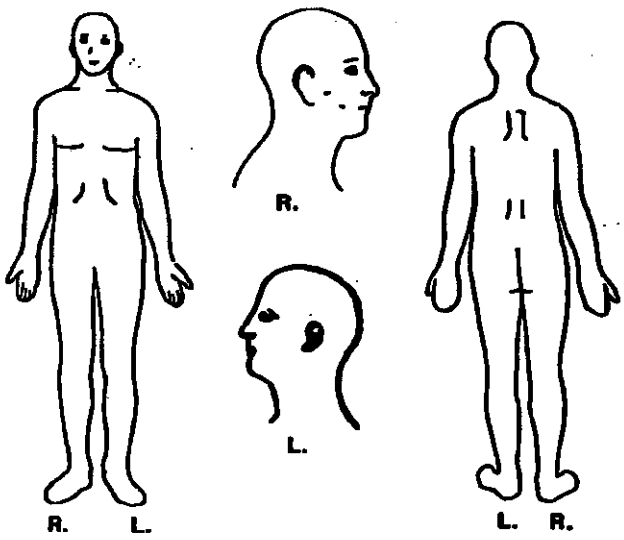
ARMS & HANDS:
- ❑ Pain in upper arm
- ❑ Pain in forearm
- ❑ Pain in hands
- ❑ Pain in fingers
- ❑ Sensation of pins & needles in arms
- ❑ Sensation of pins & needles in fingers
- ❑ Fingers go to sleep
- ❑ Hands cold
- ❑ Loss of grip strength

MID-BACK:
- ❑ Mid-back pain
- ❑ Pain between shoulder blades
- ❑ Sharp stabbing pain in mid-back
- ❑ Muscle spasms

LOW BACK:
- ❑ Low back pain
- ❑ Low back pain is worse when:
  - ❑ working
  - ❑ lifting
  - ❑ stooping
  - ❑ standing
  - ❑ sitting
  - ❑ bending
  - ❑ coughing
- ❑ Low back feels out of place
- ❑ Muscle spasms
- ❑ Arthritis

HIPS, LEGS & FEET:
- ❑ Pain in buttocks (R-L)
- ❑ Pain in hip joint (R-L)
- ❑ Pain down leg (R-L)
- ❑ Pain down both legs
- ❑ Leg cramps
- ❑ Pins & needles in legs (R-L)
- ❑ Numbness of leg (R-L)
- ❑ Numbness of feet (R-L)
- ❑ Numbness of toes
- ❑ Feet feel cold
- ❑ Cramps in feet (R-L)
- ❑ Swollen ankles (R-L)
- ❑ Swollen Feet (R-L)

*Mark Areas of Pain on Figures in Red and Rate Your Pain: 0 (least) - 10 (severe)
*Mark Areas of Tingling/Numbness in Blue




CHEST:
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Pain around ribs

GENERAL:
- ❑ Nervousness
- ❑ Irritable
- ❑ Depressed
- ❑ Fatigue
- ❑ Generally feel run-down
- ❑ Loss of sleep
- ❑ Loss of weight

ABDOMEN:
- ❑ Nervous stomach
- ❑ Nausea
- ❑ Gas
- ❑ Constipation
- ❑ Diarrhea

Briefly describe symptoms you are presently suffering from: _____

_____

Date symptoms appeared: _____ Have you lost any days work? From: _____ To: _____

Other Doctors seen for this/these conditions _____

_____

**–DO NOT WRITE BELOW THIS LINE–**

_____

_____

_____

_____

_____

_____

_____

_____

_____

FX. _____

Prior Acc. _____

D.C.'s _____

Patient accepted? ❑ Yes ❑ No Doctor's signature _____