Peakview
Chiropractic & Wellness Center

Patient # _____

PLEASE PRINT - THANK YOU

DATE _____

Name _____ Home # _____ Cell # _____

Address _____ Apt.# _____ City _____ State _____ Zip _____

E-Mail Address _____

Age _____ Birth Date _____ Marital Status M S W D Number of Children _____

Employer _____ Occupation _____

Address _____ Work Phone _____

Name of Spouse _____ Occupation _____

Spouse's Employer _____ Work Phone _____

In case of emergency, please notify _____ Relationship _____ Phone # _____

How did you hear about our office: ❑ Friend _____ ❑ Internet ❑ Website ❑ Insurance Company

❑ Relative _____ ❑ Doctor _____

Please list complaint and date the condition started, starting with your major complaints.

Complaints	*Date Started*
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

Is your condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Have you seen other doctors for your condition? ❑ Yes ❑ No

Please list other doctors seen and approximate date seen.

Doctors	*Date Started*
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Have you experienced any serious accidents or falls within the ❑ Past year ❑ Past 5 years ❑ Over 5 years ❑ Never

If you have experienced an accident, what type was it? ❑ Auto ❑ Work ❑ Home ❑ Leisure ❑ Sports ❑ Other

Briefly Explain:

_____

_____

List All Medications _____ Strength _____ Approximate Date Started _____

Supplements / Vitamins _____

Have you suffered from any serious or unusual disease _____

List surgical operations you have had and approximate date Date

_____ _____

_____ _____

_____ _____

_____ _____

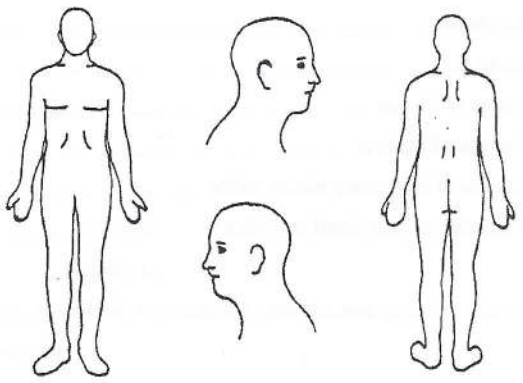
HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	❑	❑	
Used a cane, crutch, or other support?	❑	❑	
Been treated for a spine or nerve disorder?	❑	❑	
Had a fractured bone?	❑	❑	
Been hospitalized for other than surgery?	❑	❑	

CHECK YOUR PRESENT SYMPTOMS ONLY!

- ❑ Headache
- ❑ Neck Pain
- ❑ Back Pain / Upper Back
- ❑ Back Pain / Lower Back
- ❑ Stiffness
- ❑ Tight Muscles
- ❑ Arm Pain R/L
- ❑ Leg Pain R/L
- ❑ Dizziness
- ❑ Head Seems Too Heavy
- ❑ Pins & Needles in Arms
- ❑ Pins & Needles in Legs
- ❑ Numbness in Fingers
- ❑ Numbness in Toes
- ❑ Depression
- ❑ Lights Bother Eyes
- ❑ Loss of Memory
- ❑ Ears Ring
- ❑ Face Flushed
- ❑ Buzzing in Ears
- ❑ Loss of Balance
- ❑ Fainting

- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Diarrhea
- ❑ Feet Cold
- ❑ Constipation
- ❑ Cold Sweats
- ❑ Fever
- ❑ Excessive Coughing
- ❑ Swallowing Difficulty
- ❑ Burning Upon Urination
- ❑ Blood in Urine or Stool
- ❑ Shortness of Breath/Difficulty Breathing
- ❑ Stomach Upset/Gas/Vomiting
- ❑ Loss of Bladder Control
- ❑ Swelling Anywhere
- ❑ Pressure Feeling in Head and Neck
- ❑ Spots in Front of Eyes
- ❑ Heart Palpitations
- ❑ Cramps
- ❑ Hot and Cold Flashes
- ❑ Female Problems
- ❑ Pregnant

Please mark you areas of pain on the figures below.



❑ Symptoms other than above: _____

ARE YOU PREGNANT? ❑ Yes ❑ No

ARE YOU INSURED? ❑ Yes ❑ No **COMPANY** _____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore I understand that the doctor's 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 the doctor's office will be credited to my account upon receipt. 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. I further agree in case of my defaulting on this account that I will be solely responsible for all costs of collection, attorney fees, and/or court costs, necessary to recover this account. **I also understand that if I am accepted as a patient by Peakview Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic treatment will be explained to me upon request.**

Patient's Signature _____ Date _____

Signature Authorizing Care _____ Date _____

Information taken by:

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