EVEREST CHIROPRACTIC CLINIC
CONFIDENTIAL PATIENT INFORMATION

Name
(Last) _____ (First) _____ (M)_____

Social Security No. _____ Birthdate _____ Age _____

Marital: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed **Number of Children:** _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email _____

Occupation _____ Employer _____

Employer's Address _____ Office Phone _____ Ext _____

Name of Husband or Wife _____ Employer _____

Race / Ethnicity: ☐White/Caucasian ☐Hispanic/Latino/Spanish ☐Asian ☐ Black/African American
☐ Native Hawaiian ☐American Indian ☐ Other _____

Language: ☐English ☐Spanish ☐Asian ☐ Other _____

HOW DID YOU FIND OUT ABOUT OUR CLINIC ?

☐ Yellow Pages ☐ Sign ☐ Internet ☐ Ad (Please state where)_____

☐ Other person's recommendation (Please list their name) _____

☐ Other (Please Specify)_____

PLEASE LIST YOUR MAIN COMPLAINT _____

What treatment have you received for this problem ?_____

Is condition due to: Work Injury ☐Yes ☐No Auto Accident ☐Yes ☐No Other Accident ☐Yes ☐No

If yes checked above: Date of Injury _____ Did you miss time at work? ☐Yes ☐No

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PLEASE PRESENT YOUR INSURANCE CARD TO BE PHOTOCOPIED

Name of person responsible for payment _____

Are You Insured? ☐Yes ☐ No Insurance Company Name _____

Please note we cannot guarantee payment by any insurance company or government program. Any Unpaid portion of an insurance claim is the patient's responsibility. All past due accounts are subject to a 1.5 percent monthly finance charge and rebilling charges.

PATIENT SIGNATURE ⇨ _____ DATE _____
(If patient is a minor, signature of parent or guardian authorizing treatment)

(PLEASE FILL OUT BACK OF THIS FORM) ⇨

REVIEW OF SYSTEMS (Please check the box if **You** currently have or have experienced recently)

CARDIOVASCLUAR	RESPIRATORY	NEUROLOGICAL	MUSCULOSKELETAL	SKIN
☐Shortness of Breath	☐Cough	☐Headaches	☐Joint Pain, Swelling	☐Rash/Sores
☐Chest pain	☐Coughing Blood	☐Dizzy Light-headed	☐Muscle Pain	☐Lesions
☐Rapid Heartbeat	☐Shortness of Breath	☐Tremors shaking	☐Back Pain	☐Icthing/Burning
☐Swelling feet/ hands	☐Wheezing	☐Numbness	☐Cold Hands/Feet	

HEALTH HISTORY (Please check the box if **You** were ever diagnosed with, or suffered from these conditions)

☐AIDS or HIV Virus	☐Cancer	☐*High Blood Pressure*	☐Hepatitis/Liver Problems	☐Back Problems
☐Muscle/Nerve Disorders	☐Heart Disease	☐*Diabetes*	☐Respiratory /Asthma	☐Neck Problems
☐Dizziness / Vertigo	☐Heart Attack	☐Headache/Migraine	☐Epilepsy / Seizures	☐Lung Disease
☐Stomach Problems	☐Stroke	☐Kidney Problems	☐Arthritis	☐Bowel Problems
☐Depression/Anxiety	☐Alcohol Issues	☐Drug/Substance Abuse		

Have you suffered from any other serious disease or medical problem? (Please describe):_____

_____

FAMILY HISTORY (Please check the box if any **Family Member** has been diagnosed with any of the following.)

☐Cancer	☐High Blood Pressure	☐Heart Attack	☐Stroke	☐Kidney Problems
☐Heart Disease	☐Diabetes	☐Respiratory/ Lung problems		☐Hepatitis/Liver Problems

History of any other health problems that run in your family? _____

_____

Please list your: *Current height* _____ *Current weight* _____

Have you ever broken a bone? ☐Yes ☐No Have you ever been hospitalized for any illness or surgery? ☐Yes ☐No

Have you been treated by a doctor for any health conditions in the last year? ☐Yes ☐No

Name of your family physician _____ Clinic Name: _____

Have you ever been involved in a car accident or other serious accident or fall? ☐Yes ☐No

Any serious accidents or falls within the last year? ☐Yes ☐No

List your current prescription medications and non prescription medications you are currently taking: ☐ None

_____

_____

List your current Allergies (medications, other): ☐ None

_____

_____

List; vitamins, minerals or herbal supplements you are taking: ☐ None _____

HEALTH HABITS

Do you smoke cigarettes or tobacco?	☐Never	☐Former Smoker	☐Current Smoker ____ packs per day	
Caffeine drinks; coffee, soda, tea, etc?	☐No	☐1-2 per day	☐3-5 per day	☐6 or more per day
Do you drink alcohol?	☐No	☐1-3 drinks / week	☐4-10 drinks / week	☐11 or more drinks /week
Do you use Street/Recreational Drugs?	☐No	☐Yes		
Do you exercise regularly?	☐No	☐1-2 times per week	☐3 or more times per week	

Rate the current level of stress you feel. 1-10 (10 being the highest level of stress) _____

FEMALE ONLY:

Are you pregnant ☐Yes ☐No

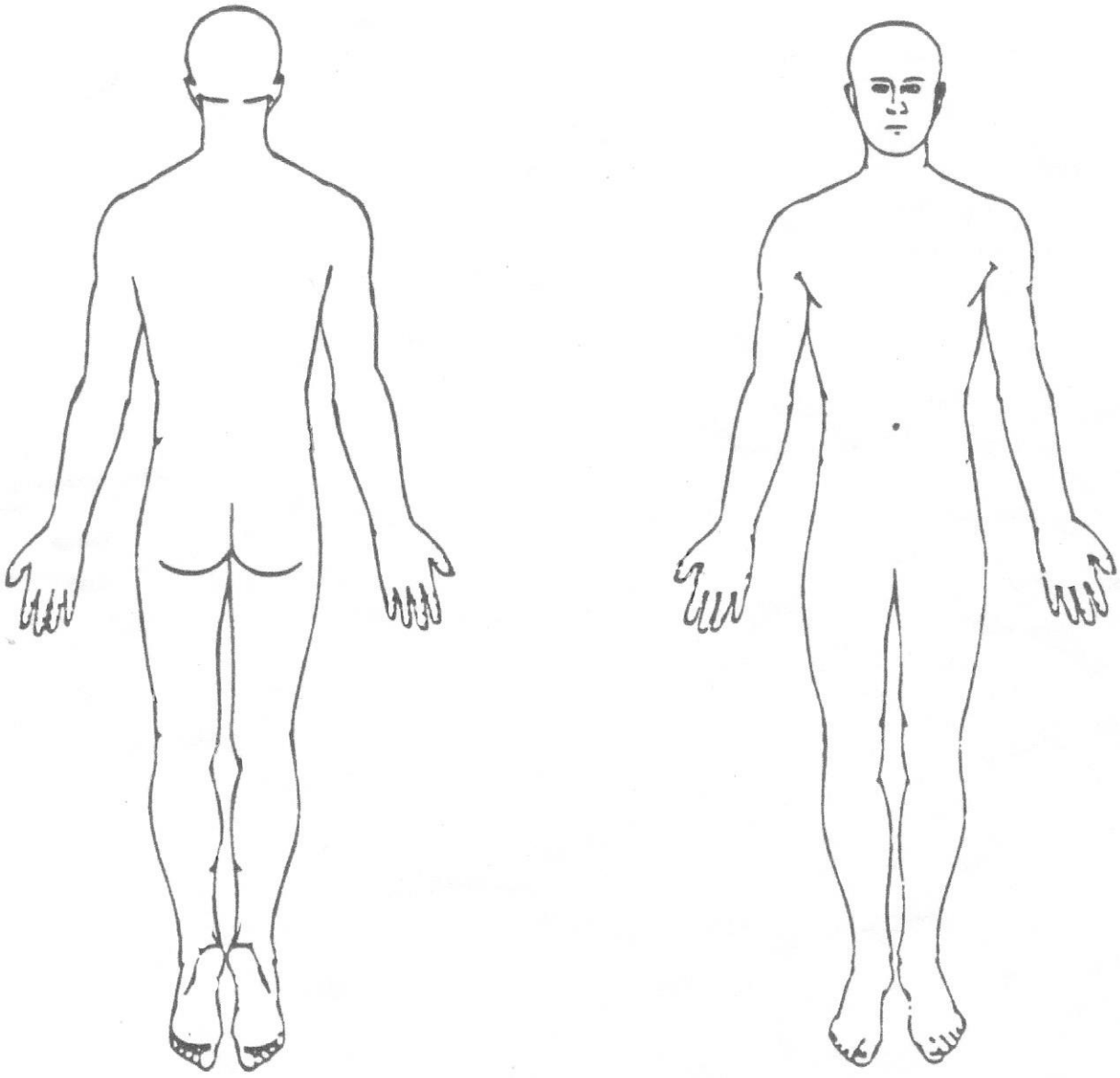
SIGNATURE ⇨ _____ DATE _____

EVEREST CHIROPRACTIC CLINIC, S.C. VAS ANALOG PAIN SCALE

Name: _____ Date: _____

Mark the area on your body where you feel the described sensation. Use the appropriate symbol.

Numbness - - - - -	Pins & 00000	Burning xxxxx	Stabbing /////	Aching (((((
- - - - -	Needles 00000	Pain xxxxx	Pain /////	Pain (((((



No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Circle your pain estimate

How often do you experience your symptoms?

- ☐ Constantly (76-100 % of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50 % of the day)
- ☐ Intermittently (0-25 % of the day)

How Are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse