

**CHIRO 1 EXPRESS**  
**CONFIDENTIAL PATIENT INFORMATION**

**PERSONAL INFORMATION**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

PHONE: (\_\_\_\_\_) \_\_\_\_\_ MOBILE:(\_\_\_\_\_) \_\_\_\_\_

E-MAIL: \_\_\_\_\_

MARRIED: YES \_\_\_ NO \_\_\_ NUMBER OF CHILDREN (if applicable): \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ OFFICE PHONE: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_/\_\_\_/\_\_\_ SS#: \_\_\_\_\_

IN CASE OF EMERGENCY, NOTIFY (other than spouse): \_\_\_\_\_

ADDRESS: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE: \_\_\_\_\_

WHAT BROUGHT YOU TO OUR OFFICE: \_\_\_\_\_

NAME OF MEDICAL DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

INSURANCE CO. NAME \_\_\_\_\_ POLICY# \_\_\_\_\_

PHONE: \_\_\_\_\_ CLAIM# \_\_\_\_\_

SECONDARY INS. CO. NAME \_\_\_\_\_ POLICY# \_\_\_\_\_

PHONE: \_\_\_\_\_ GROUP# \_\_\_\_\_

GUARANTOR: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

The following points are important that you read and agree to in order for you to become a patient at our clinic.

- All services rendered will be considered cash until your insurance is verified.
- If you are unable to keep your appointment, we require that you call ahead to cancel so that someone else, if needed, can be put in your appointed time.
- Payment for services rendered that day are due before we leave unless other financial arrangements have been made.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I understand that Chiro 1 Express 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 upon receipt. I permit Chiro 1 Express to endorse remittances on my behalf. However, I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment, payment in full may become due and payable immediately. Furthermore, I understand that should my account for any reason become delinquent, I may be responsible for including but not limited to collection agency fees, court costs, legal fees and interest.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Confidential History

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ DATE \_\_\_\_\_  
AGE: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

### PATIENT CONDITION

Reason for Visit: \_\_\_\_\_

Date symptoms began: \_\_\_\_\_  Gradual  Sudden

Is condition getting worse?  Yes  No Is the pain constant or comes / goes? \_\_\_\_\_

How often do you have this pain?  Daily  Other \_\_\_\_\_

Circle severity of your pain (1= Mild pain to 10 severe pain) 1 2 3 4 5 6 7 8 9 10

Condition is due to:  Auto  Home  Other \_\_\_\_\_

Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Cramps  Tingling  Swelling  Other \_\_\_\_\_

Does your pain radiate to any other part of your body?  Yes  No If YES, describe: \_\_\_\_\_

Which activities are difficult to perform?  Sitting  Standing  Walking  Bending  Lying down  
 Other: \_\_\_\_\_

Name of Doctor (s) that have treated you for this condition? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What diagnosis did the Doctor (s) give you? \_\_\_\_\_  
\_\_\_\_\_

What treatment have you already received for your condition?  Medication  Surgery  
 Physical Therapy  Chiropractic  Other \_\_\_\_\_ Date of last treatment: \_\_\_\_\_  
Date of last physical examination: \_\_\_\_\_

X-rays or other imaging taken recently?  Yes  No If so, what area(s), for what reason and when: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the intensity of the pain awaken you from your sleep?  Yes  No If YES, describe: \_\_\_\_\_  
\_\_\_\_\_

Have you gain or lost weight recently without trying?  Yes  No If YES, describe: \_\_\_\_\_  
\_\_\_\_\_

Have you ever had anything like this before?  Yes  No If YES, describe: \_\_\_\_\_  
\_\_\_\_\_

# Confidential Health History

LAST NAME, FIRST:

DATE:

**MEDICATIONS:** List medications you are currently taking

**ALLERGIES:** List all allergies

**HOSPITALIZATIONS / FRACTURE BONES**

**PREGNANCIES**

YEAR	HOSPITAL	REASON

YEAR	SEX	COMPLICATIONS

Have you ever had a blood transfusion:  Yes  No

If YES, give reason and dates:

Check (√) which substances you use and how much

Caffeine

Tobacco

Drugs

SERIOUS ILLNESS / INJURIES      DATE

Check (√) if your job exposes you to :

Stress

Heavy Lifting

Other

**FAMILY HISTORY:**

Check (√) BELOW AND INDICATE RELATION

RELATION	AGE	STATE OF HEALTH	Age at death	Cause of Death	Disease	Relationship
FATHER					ARTHRITIS	
MOTHER					GOUT	
BROTHERS					CANCER	
					CHEMICAL DEPENDENCY	
					DIABETES	
SISTERS					STROKE	
					HIGH BLOOD PRESSURE	
					KIDNEY DISEASE	
					TUBERCULOSIS	
					OTHER	

I hereby certify that the information provided on this form is true and correct to the best of my knowledge:

Patient Signature:

Date:

**DO NOT WRITE BELOW THIS LINE PHYSICIAN USE ONLY**

MACRO 1 PMHX

MACRO 11 PMHX

MACRO 2 PSHX

MACRO 22 PSHX

MACRO 3 SFHX

MACRO 33 SFHX

MACRO 4 MEDS

MACRO 44 MEDS

MACRO 6 Drug

MACRO 66 Drug

Physician Initials

# Confidential Health History

LAST NAME	FIRST	DATE: / /
Age:	Date of Birth	/ /

**SYMPTOMS: CHECK (√) ANYTHING YOU HAVE NOW OR HAVE HAD IN THE LAST YEAR**

<p><b>GENERAL</b></p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headaches <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Loss of Weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p><b>GASTROINTESTINAL</b></p> <input type="checkbox"/> Appetite Poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel Changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive Hunger <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Stomach Pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting Blood	<p><b>Eye Ear Nose Throat</b></p> <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Double Vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear Discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of Hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision Flashes <input type="checkbox"/> Vision - Halos	<p><b>Men only</b></p> <input type="checkbox"/> Breast Lump <input type="checkbox"/> Erection Difficulties <input type="checkbox"/> Lump in Testicles <input type="checkbox"/> Penis Discharge <input type="checkbox"/> Sore on Penis
<p><b>MUSCLE/JOINTS</b>  <i>Pain, weakness, numbness in:</i></p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p><b>CARDIOVASCULAR</b></p> <input type="checkbox"/> Chest Pain <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Irregular Heart beat <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Rapid heart Beat <input type="checkbox"/> Swelling of Ankles <input type="checkbox"/> Varicose Veins	<p><b>SKIN</b></p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in Moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p><b>Women Only</b></p> <input type="checkbox"/> Abnormal PAP <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast Lump <input type="checkbox"/> Extreme Menstrual Pain <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Other _____
			<p>Date of Last period _____          Date of last PAP test _____          Have you had a mamogram? _____          Are you pregnant? _____          Number of Children _____</p>

**CONDITIONS: CHECK (√) ANYTHING YOU HAVE NOW OR HAVE EVER HAD**

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulemia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measels <input type="checkbox"/> Migraines <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problems <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infection <input type="checkbox"/> Venereal Disease
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**DO NOT WRITE BELOW THIS LINE PHYSICIAN USE ONLY**

MACRO 5 ROS     MACRO 55 ROS  
 MACRO 1 PMHX     MACRO 11 PMHX

Physician Initials

## INITIAL PATIENT SYMPTOM QUESTIONNAIRE

<b>PATIENT NAME:</b>	<b>TODAY'S DATE:</b>	<b>Age:</b>	<b>Ht:</b>
<b>CHART NO.:</b>	<b>DATE OF ACCIDENT:</b>	<b>Wt:</b>	<b>Sex: M / F</b>

Check the box or boxes below If you ever experience the symptom(s) indicated as a result of your injuries.	How bad is your pain? Circle a number that best describes your pain when it is at its worst. 1 is mild pain 10 is the worst pain.	How often do you experience the symptom checked? Check the box that best describes how often you experience your pain.
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<input type="checkbox"/> HEADACHES	1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> CONSTANT	<input type="checkbox"/> FREQUENT
		<input type="checkbox"/> INTERMITTENT	<input type="checkbox"/> OCCASSIONAL
<input type="checkbox"/> NECK PAIN	1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> CONSTANT	<input type="checkbox"/> FREQUENT
		<input type="checkbox"/> INTERMITTENT	<input type="checkbox"/> OCCASSIONAL
<input type="checkbox"/> MID BACK PAIN	1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> CONSTANT	<input type="checkbox"/> FREQUENT
		<input type="checkbox"/> INTERMITTENT	<input type="checkbox"/> OCCASSIONAL
<input type="checkbox"/> LOW BACK PAIN	1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> CONSTANT	<input type="checkbox"/> FREQUENT
		<input type="checkbox"/> INTERMITTENT	<input type="checkbox"/> OCCASSIONAL
<input type="checkbox"/> Right SHOULDER PAIN	1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> CONSTANT	<input type="checkbox"/> FREQUENT
		<input type="checkbox"/> INTERMITTENT	<input type="checkbox"/> OCCASSIONAL
<input type="checkbox"/> Left SHOULDER PAIN	1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> CONSTANT	<input type="checkbox"/> FREQUENT
		<input type="checkbox"/> INTERMITTENT	<input type="checkbox"/> OCCASSIONAL
<input type="checkbox"/> Right KNEE PAIN	1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> CONSTANT	<input type="checkbox"/> FREQUENT
		<input type="checkbox"/> INTERMITTENT	<input type="checkbox"/> OCCASSIONAL
<input type="checkbox"/> Left KNEE PAIN	1 2 3 4 5 6 7 8 9 10:	<input type="checkbox"/> CONSTANT	<input type="checkbox"/> FREQUENT
		<input type="checkbox"/> INTERMITTENT	<input type="checkbox"/> OCCASSIONAL
<input type="checkbox"/> Numbness/Tingling Right Arm/Hand	1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> CONSTANT	<input type="checkbox"/> FREQUENT
		<input type="checkbox"/> INTERMITTENT	<input type="checkbox"/> OCCASSIONAL
<input type="checkbox"/> Numbness/Tingling Left Arm/Hand	1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> CONSTANT	<input type="checkbox"/> FREQUENT
		<input type="checkbox"/> INTERMITTENT	<input type="checkbox"/> OCCASSIONAL
<input type="checkbox"/> Numbness/Tingling Right Leg/Foot	1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> CONSTANT	<input type="checkbox"/> FREQUENT
		<input type="checkbox"/> INTERMITTENT	<input type="checkbox"/> OCCASSIONAL
<input type="checkbox"/> Numbness/Tingling Left Leg/Foot	1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> CONSTANT	<input type="checkbox"/> FREQUENT
		<input type="checkbox"/> INTERMITTENT	<input type="checkbox"/> OCCASSIONAL
<input type="checkbox"/> _____	1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> CONSTANT	<input type="checkbox"/> FREQUENT
		<input type="checkbox"/> INTERMITTENT	<input type="checkbox"/> OCCASSIONAL
<input type="checkbox"/> _____	1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> CONSTANT	<input type="checkbox"/> FREQUENT
		<input type="checkbox"/> INTERMITTENT	<input type="checkbox"/> OCCASSIONAL

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Office Use Only:	Macro 15 CC <input type="checkbox"/>
	Macro 13 PE <input type="checkbox"/>

**Examiner Initials:** \_\_\_\_\_

<b>PATIENT NAME:</b>	<b>TODAY'S DATE:</b>
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**PLEASE CHECK THE BOX NEXT TO ANY SYMPTOM WHICH YOU EXPERIENCE:**

- BLURRED VISION**       **DIZZINESS**       **IMBALANCE**       **DYSCORDINATION**
- SHORT TERM MEMORY LOSS**       **NERVOUSNESS WHEN IN VEHICLES**       **FATIGUE**
- DIFFICULTY SLEEPING**       **INCREASED PAIN IN THE MORNING**       **LOSS OF ENERGY**
- ANXIETY**       **INCREASED PAIN IN COLD/DAMP WEATHER**
- PAIN DURING SEXUAL ACTIVITY**

**PLEASE CHECK THE BOX NEXT TO ANY OF THE FOLLOWING WHICH CAUSE YOU INCREASED PAIN.**

- ATTEMPTNG TO LIFT OBJECTS**       **BENDING NECK FORWARD**       **BENDING NECK BACKWARDS**
- BENDING FORWARD**       **LEANING/BENDING BACKWARD**
- EXTENDING ARMS OVERHEAD**       **PUSHING HEAVY OBJECTS (DOORS, SHOPPING CARTS)**
- STRAINING TO MOVE BOWELS**       **PROLONGED SITTING**       **PROLONGED STANDING**
- COUGHING OR SNEEZING**       **WALKING**       **ASCENDING/DESCENDING STAIRS**
- DRIVING**       **CHILDCARE**       **HOUSEHOLD DUTIES**
- READING/PAPERWORK/COMPUTER WORK**

**PLEASE WRITE ANY ADDITONAL INFORMATION YOU WISH TO ADD:**

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**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Office Use Only:	Macro 15 CC	<input type="checkbox"/>
	Macro 13 PE	<input type="checkbox"/>

**Examiner Initials:** \_\_\_\_\_