

Performance Chiropractic
Patient Information Record

Today's Date: _____

Patient's Name:

Last

First

MI

Address:

Street

City

State

Zip

Home Phone(____) _____ Work(____) _____

Cellular(____) _____

(Please circle the best number to reach you during the day)

Sex: ____M ____F

Date of Birth: ____/____/____ Age: _____

Social Security #: ____/____/____

Employer:

Occupation (list job description, ie sitting at a computer):

Emergency Information

Person to call: _____

Relationship: _____

Phone: (____) _____

Payment is required at the time of service. Most insurance companies cover Chiropractic services, but I understand that I am financially responsible for all charges incurred.

Signature of Patient or Legal Guardian: _____

Please check payment method:

____Cash

____Check

____Mastercard/Visa

**Please present your insurance cards and picture ID to the receptionist so that
we may help you with your insurance**

How did this condition develop? (What caused it? How did it start?)_____

When were you first aware of this problem? _____

Have you ever had this problem or similar problems before? If yes, please explain: _____

Have you ever received any treatment for this condition? If yes, where and when, and what were your results? _____

Has this problem been getting better, worse or staying the same? _____

Is there anything that makes this problem worse? _____

How has this condition affected your life?

1. Home life _____

2. Occupational life _____

3. Recreational life _____

4. Rest and sleep life _____

Have you been in an automobile accident? If yes, when _____

Any accidents, falls, etc that could have caused this problem? (Please explain)_____

Are you pregnant? If so, what is your due date? _____

Any chiropractor consulted in the past? Name: _____

Dates consulted: _____ **For what problem?** _____