**COLEMAN CHIROPRACTIC CLINIC**

Phone: 318.388.2215 Email: **colemanchiro2501@gmail.com** Web: [**www.colemanchiropractic.net**](http://www.colemanchiropractic.net)

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST.

**PATIENT INFORMATION** Chart #\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­ ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Male Female

Marital Status:  Married  Single  Divorced  Separated  Minor Child

Name of Spouse or Nearest Relative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred to this office by:  Friend/Family  Yellow Pages  Mail  Clinic Location  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payment for Services will be by:  Self Pay  Health Insurance  Auto Insurance  Worker’s Compensation

* Patient/Guardian will need to provide all Insurance Information and an ID.

**MEDICAL/FAMILY HISTORY S = Self M= Mother F = Father**

(Please indicate which conditions have been experienced by the above by marking appropriate boxes.)

S M F S M F S M F

   AIDS    Dislocated Joints    Neck Pain

   Anemia    Epilepsy    Nervousness

   Arthritis    German measles    Numbness

   Asthma    Headaches    Polio

   Back Pain    Heart Trouble    Poor Circulation

   Bladder Trouble    Reproductive Disorders    Hepatitis

   Bone Fracture    High Blood Pressure    Rheumatic Fever

   Cancer    HIV/ARC    Rheumatism

   Chest Pain    Kidney Disorder    Scarlet Fever

   Concussion    Bowel Control Loss    Serious Injury

   Convulsion    Menstrual Cramps    Sinus Trouble

   Diabetes    Multiple Sclerosis    Tuberculosis

   Indigestion    Muscular Dystrophy    Venereal Disease

Have you been treated by a physician for any health condition in the last year?  Yes  No

Describe Condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Physical Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SURGICAL HISTORY:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a metal implant?  Yes  No Ever been gunshot?  Yes  No

ACCIDENT HISTORY:  Job  Auto  Other 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  Job  Auto  Other 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim number to accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have an attorney? \_\_\_No \_\_\_ Yes, Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Need additional space you can write on back.

**PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:**

Need additional space you can write on back.

(PLEASE RATE YOUR SYMPTOMS ON A SCALE FROM 1-10 WITH 10 BEING THE WORST PAIN AND 1 BEING THE LEAST.)

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Symptoms are worse in  Morning  Afternoon  Night

When and how occurred?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Symptoms developed from:  Job Related Injury  Auto Accident  Other  Illness  Unknown  Gradual Onset

Symptoms have persisted for: \_\_\_\_Hour(s) \_\_\_\_Day(s) \_\_\_\_Week(s) \_\_\_\_Month(s) \_\_\_\_Year(s)

Symptoms/Complaints: Come & Go  Are Constant

Have you had this before:  No  Yes If yes, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­\_\_\_\_

If you were to guess, what do you think is causing your complaints?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and location of doctors previously seen for present condition(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had X-rays taken in the past year?  No  Yes If yes, where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications?  No  Yes If yes, what kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications?  No  Yes If yes, what kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant?  No  Yes If no, date of last menstrual period?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently experiencing any of the following?

 Double Vision  Rapid eye Movement  Dizziness  Numbness on one side of the face or body Difficulty Walking Faintness or lightheadedness  Difficulty Speaking Headache or neck pain like you have never had before Difficulty swallowing  Nausea or vomiting

Please check the following activities that AGGRAVATE your condition:

 Bending  Reaching  Straining at Stool  Coughing  Sitting  Turning Head  Lifting  Sneezing  Walking  Lying Down  Standing

Please check the following activities that RELIEVE your condition:

 Bending  Sitting  Lifting  Standing  Lying Down  Turning Head  Reaching  Walking

Please check any additional symptoms you may be experiencing:

 Blurred Vision  Buzzing in ears  Cold Feet  Cold Hands  Cold Sweats  Concentration loss/Confusion Constipation  Depression/Weeping Spells  Diarrhea  Dizziness  Face Flushed  Fainting  Fatigue  Fever  Head seems to heavy  Headaches  Insomnia Light Bothers Eyes  Loss of balance  Loss of smell  Loss of taste  Low resistance to colds  Muscle Jerking  Numbness in fingers Numbness in toes  Pins and needles in arms  Pins and needles in legs  Ringing in ears Shortness of Breath  Stiff neck  Stomach Upset

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If minor, I hereby grant permission for my child to receive chiropractic care.

Parent/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/ Guardian Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Printed Name :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pt. Chart # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date Of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_