



REEDCHIROPRACTIC

Dr. David T. Reed, Chiropractor

Patient Information

Name: _____ Date: _____ SS#: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Sex: Female Male Birthday: _____ Email: _____
 Home Phone #:() _____ Cell #:() _____ Work #:() _____
 Where do you prefer to receive calls at? Home Cell Work No preference
 Are you: Married Single Minor Partnered Divorced
 Patient Employer/School: _____ Occupation: _____
 Employer/School Address: _____ City: _____ State: _____
 Spouse or Parents Name: _____
 Who should we contact in case of an emergency?: _____ Phone #:() _____
 Whom may we thank for referring you to our office?: _____

Responsible Party

Name of person responsible for this account: _____
 Relationship to Patient: _____ Phone #:() _____
 Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Name of insured: _____ Relationship to patient: _____
 Birthday: _____ Social Security #: _____
 Name of employer: _____ Date employed: _____
 Insurance Co.: _____ Phone #: () - _____ Group #: _____

Certification and Assignment

- To the best of my knowledge, the above information is complete and correct. I understand this is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.
- I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Reed all insurance benefits, if any, otherwise payable to me for services rendered.
- I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian	Date
Please print name of Patient, Parent, Guardian	Relationship to Patient

Patient Name: _____

Date: _____



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Personal Health History

Reason for today's visit: Wellness Visit Chronic Pain New Injury Old Injury
 Did your injury occur during: Work Sleep Sports/Play Auto Accident Routine/Household Activity
 When did your condition/accident occur?: ____/____/____ Where did your injury occur?: _____
 Please explain what happened: _____

Is your condition getting worse?: Yes No Comes and Goes
 Is your condition interfering with your: Work Sleep Daily Routine Recreation
 If so, how?: _____
 Has this or something similar happened in the past?: Yes No
 Explain: _____

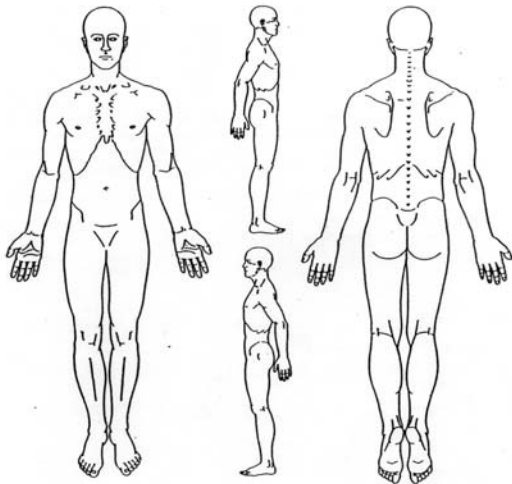
Are you in pain? Circle one: Yes No

Rate your pain on the following scale for each area of your body:

(No Pain) 0 - 10 (Severe Pain)

Neck:____ Mid-Back:____ Lower Back:____ Other: _____ pain:____

Using the body chart below, please circle all affected areas:



Have you been treated by a medical physician for this pain?: Circle One: Yes No
 If so, where?: _____

Have you ever been treated by a chiropractor?
 Circle One: Yes No
 Clinic or Doctor's Name: _____

Are you taking any of the following medications?
 Nerve Pills
 Pain Killers (including aspirin)
 Muscle Relaxors
 Blood Thinners
 Tranquilizers
 Insulin
 Other(s): _____

Do you or have you had any of the following diseases, medical conditions or procedures?

- | | | | | |
|-----------------------------|--------------------------------|-------------------------|-------------------------------|---------------------------|
| Y N Heart Attack/Stroke | Y N Heart Surgery/Pacemaker | Y N Heart Murmur | Y N Congenital Heart Defect | Y N Mitral Valve Prolapse |
| Y N Artificial Valves | Y N Alcohol/Drug abuse | Y N Venereal Disease | Y N Hepatitis | Y N Anemia/Diabetes |
| Y N Shingles | Y N Cancer | Y N Frequent Neck Pain | Y N Glaucoma | Y N Kidney Problem |
| Y N High Low Blood Pressure | Y N Psychiatric Problems | Y N Rheumatic Fever | Y N Artificial Bones/Joints | Y N Tuberculosis |
| Y N Ulcers/Colitis | Y N Fainting/Seizures/Epilepsy | Y N Sinus Problems | Y N Emphysema/Asthma | Y N Arthritis |
| Y N Difficulty Breathing | Y N Chemotherapy | Y N Lower back Problems | Y N Severe/Frequent Headaches | |

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Family Health History

Do you take any supplements or vitamins?

Do you exercise? Yes No How many hours per week?: _____

Do you smoke? Yes No How much?: _____ How Long?: _____

Are you wearing?: shoe lifts inner soles arch supports

Are you dieting?: Yes No If yes, since when?: _____

For Women:

Are you taking birth control pills?: Yes No

Are you nursing?: Yes No

Are you Pregnant?: Yes No If so, how many weeks: _____

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Signature of Patient, Parent, Guardian

Date