PERFORMANCE CHIROPRACTIC

Patient Information

Welcome to Performance Chiropractic. We are very pleased that you have selected us as your health care provider. We are looking forward to a very healthy relationship and would like to encourage you to visit our website (www.performancechiropracticonline.com) for additional information.

Patient Name: ______________________________ ☐ Male ☐ Female

Address: ____

City: ____________________ State: _____________ Zip: ____________________

Birthdate: ___/___/_____ Age: ________ Social Security Number: ______-_____-__________

Home #: ( ) __________________ Cellular #: ( ) _____________________________

Work : ( ) ____________________ Ext ________ Fax #: ( )________________________

E-Mail Address: ____

☐ Single ☐ Married Height: ____________ Weight: ____________

Employer: ____________________________ Occupation: _______________________________

Employer Address: ____________________ City: _____________ State: ______ Zip: ________

Emergency Contact: _________________________ Phone Number: ______________________

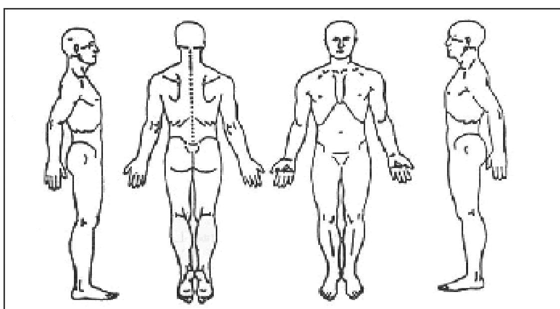
Reason for consulting our office: ____

Referred By: ______________________ Do you have health insurance? ☐ Yes ☐ No

Your current Medical Doctor's first and last name: _______________________________

Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation ☐ Other Accident/Fall

1. Indicate on the drawings below where you have pain/symptoms:



2. How long have you had this problem? ____

3. How do you think your problem began? ____

4. How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)

☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

5. How would you describe the type of pain?

☐ Sharp ☐ Numb
☐ Dull ☐ Tingly
☐ Diffuse ☐ Sharp with motion
☐ Achy ☐ Shooting with motion
☐ Burning ☐ Stabbing with motion
☐ Shooting ☐ Electric like with motion
☐ Stiff ☐ Other: ________________

5. How are your symptoms changing with time? ☐ Getting worse ☐ Staying the same ☐ Getting better

6. List all prescription medications you are currently taking: ____________________________________

____

7. Which conditions are you taking the above medications for? ________________________________

____

8. List all of the over-the-counter medications you are currently taking:

____

9. List all surgical procedures you have had: ____

____

10. What are your goals with spinal care? ____

____

11. What things interest you or would you like to learn more about? Please check those items that apply:

☐ Nutrition ☐ Family Health
☐ Exercise ☐ Wellness
☐ General Health ☐ Sports Enhancement
☐ Immune Function Improvement

I consent to a professional and complete chiropractic examination.
I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

CLINIC LATE CANCELLATION FEE POLICY

Your appointment times have been reserved for you. In order to offer timely and optimal care for all our patients, we request 24 hour notice for cancellation of visits. Kindly provide us notice by calling the front desk. Please always leave a message if your call goes directly to our voicemail.
* Please note that in the case of **massage** appointments, **you will be charged a $35 fee for any visit cancellations without 24 hours notice**.*

I, ____________________________, have read and understand the above fee policy.

Print Patient Name: ____________________________________

Signature: ____ Date: _______________________