Welcome to Lowrey Chiropractic

In order to provide you the best possible chiropractic wellness care, please complete this form (print clearly).
All information is strictly CONFIDENTIAL.

Patient Information *(please print clearly)*

Name: _____ Date:_____ E-mail:_____
First Name Middle Initial Last Name
Your email will NOT be shared with any 3rd parties, and is used for general office announcements and promotions.

Address: _____ City:_____ State:_____ Zip Code: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____ Sex: M / F

Birthdate: _____ Age:_____ Social Security #:_____ ❑ Married ❑ Single ❑ Widowed ❑ Divorced

Patient Employer/School: _____ Occupation: _____

Employer Address: _____ City:_____ State:_____ Zip Code: _____

Spouse or Parent's Name:_____ Spouse's Employer: _____ Work Phone: (_____)_____

How did you hear about us? _____ Whom may we thank for referring you to us?_____

Person to contact in case of emergency:_____ Phone: (_____)_____

Insurance Information

Subscriber Name: _____ Relation to Patient: _____

Insurance Company: _____ Type of Health Plan: ❑ PPO ❑ HMO ❑ Other

Insurance Company Address:_____ City:_____ State:_____ Zip Code: _____

Subscriber/ID #:_____ Group #:_____ Insurance Co. Phone: (_____)_____

Reason for Visit

Reason for ***this*** visit: _____

Rate the severity of your pain. **Mild Discomfort 1 2 3 4 5 6 7 8 9 10 Intense Pain**

When did your condition/accident occur? _____ Where did your injury occur? _____

Please explain what happened:_____

How ***often*** are your symptoms present? ❑ 0 - 25% ❑ 26-50% ❑ 51-75% ❑ 76-100%

Have you had similar conditions in the past? ❑ Yes ❑ No If yes, When? _____

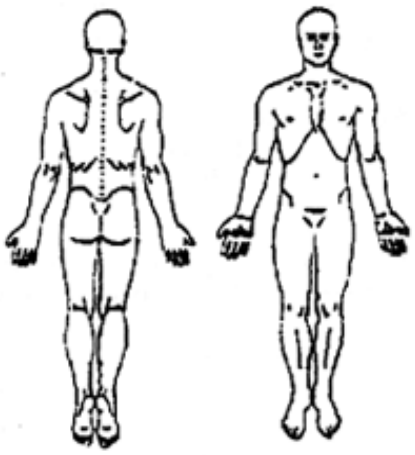
Have you ever been treated by a chiropractor? ❑ Yes ❑ No If yes, when and for what condition? _____

Have you been treated by any other doctors or health professionals for this Pain? ❑ Yes ❑ No If yes, where?_____

Which activities are difficult to perform? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑ Lifting

Is pain interfering with: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation
❑ Other _____

Using the adjacent body chart, please circle ALL affected areas.



Type of pain:

❑ **Sharp**	❑ **Dull**	❑ **Throbbing**
❑ **Burning**	❑ **Tingling**	❑ **Cramping**
❑ **Numbness**	❑ **Aching**	❑ **Shooting**
❑ **Stiffness**	❑ **Swelling**	❑ **Other**

Is pain getting: ❑ Worse ❑ Better ❑ Same ❑ Comes & Goes

Is the pain worse in: ❑ AM ❑ PM ❑ N/A

Health History

Please list any serious injuries you have had in the last 10 years:

			Date:	Briefly Explain:
Broken Bones:	❑ No	❑ Yes	_____	_____
Falls:	❑ No	❑ Yes	_____	_____
Head Injuries:	❑ No	❑ Yes	_____	_____
Dislocations:	❑ No	❑ Yes	_____	_____
Surgeries	❑ No	❑ Yes	_____	_____
Other Serious Injuries	❑ No	❑ Yes	_____	_____

Please list anything that you may be allergic to: _____

Please list any medications (including pain killers) you are taking and why: _____

(Woman) Are you pregnant? ❑ No ❑ Yes Nursing? ❑ No ❑ Yes Taking Birth Control Pills? ❑ No ❑ Yes

Medical Conditions

Please Check whether you have had or currently have any of the following medical conditions?

- ❑ Heart Attack/Stroke
- ❑ Congential Heart Defect
- ❑ Diabetes/Tuberculosis
- ❑ Fainting/Seizures
- ❑ Epilepsy
- ❑ Dizziness
- ❑ Ringing in Ears
- ❑ Difficulty Breathing
- ❑ Heart Disease
- ❑ Anemia
- ❑ Emphsema/Glaucoma
- ❑ Rheumatic Fever
- ❑ Multiple Sclerosis
- ❑ Headaches/Migraines
- ❑ Arthritis
- ❑ Rheumatoid Arthritis
- ❑ Osteoporosis
- ❑ Kidney Problems
- ❑ Artificial Bones/Joints
- ❑ Implants
- ❑ Cancer
- ❑ Ulcer/Colitis
- ❑ Gout
- ❑ AIDS/HIV
- ❑ Hepatitis
- ❑ Alcohol/Drug Abuse
- ❑ High Cholesterol
- ❑ High Blood Pressure
- ❑ Stomach Pain
- ❑ Frequent Neck Pain
- ❑ Jaw Pain
- ❑ Wrist Pain
- ❑ Shoulder Pain
- ❑ Arm Pain
- ❑ Leg Pain
- ❑ Lower Back Problems
- ❑ Severe/Frequent Earaches
- ❑ Appendicitis
- ❑ Pacemaker
- ❑ Nervousness
- ❑ Irritable
- ❑ Depressed
- ❑ Fatigue
- ❑ Generally feel run-down
- ❑ Loss of sleep
- ❑ Loss of weight
- ❑ Loss of balance
- ❑ Shortness of Breath
- ❑ Chest Pain
- ❑ Nervous Stomach
- ❑ Swollen Joints
- ❑ Stiff Neck
- ❑ Psychiatric Problems
- ❑ Chicken Pox
- ❑ Measles
- ❑ Shingles
- ❑ Pneumonia
- ❑ Scarlet Fever
- ❑ Ulcers
- ❑ Other (specify)

_____
_____
_____
_____
_____

Daily Habits

What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑ Heavy

What do your daily work habits include? _____

What vitamins do you currently take?_____ Nutritional supplements? _____

Do you smoke? ❑ Yes ❑ No How much per day? _____

How much liquor do you consume weekly? _____ How much caffeinated beverages do you consume daily? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it 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 Lowrey Chiropractic 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.

Lowrey Chiropractic 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 or the benefits payable for related services.

I have been presented with a copy of the *Notice of Privacy Practices,* detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient