Welcome to Lighthouse Family Chiropractic Center!!!

Patient Name: _____ **Date:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Home Phone:** _____

Birth date: _____ **Sex:** _____ **Cell Phone:** _____

Age: _____ **Height:** _____ **Weight:** _____ **Race:** _____

Language Spoken: _____ **Ethnicity:** □ **Hispanic or Latino** □ **Non Hispanic or Latino**

Marital Status: _____ **# Of Children:** _____ **Social Security #:** _____

Occupation: _____ **Employment:** _____

Work Address: _____

Work phone#: _____ **E-mail:** _____

Do you Smoke: □ **Yes, Date started** ____/____/_____**how much** _____ □ **Former smoker: quit date:** _____/_____/_____

□ **No, Never smoked**

Primary Insurance Co: _____ **Ins. Phone#:** _____

Policy#: _____ **Group#:** _____

Primary insured name: _____ **Birth date:** ___/_____/_____ **Rel. to patient**_____

Address (if different than patient) _____

Secondary Insurance Co: _____**Ins. Phone#:** _____

Policy#: _____ **Group#:** _____

Primary insured name: _____ **Birth date:** ___/_____/_____ **Rel. to patient**_____

Address (if different than patient) _____

Reason for today's visit: □ Emergency □ New Injury □ Old Injury □ Chronic Pain □ Wellness Visit

Are you in pain: □ Yes □ No Rate your pain with the following scale

Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Did your injury occur during: □ Work □ Sports/Play □ Auto Accident □ Routine/Household Activities

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

Please explain what happened: _____

Is your condition getting worse? □ Yes □ No □ Constant □ Comes and goes

Is your condition interfering with your: □ Work □ Sleep □ Daily Routine? If so, how _____

_____

Has this or something similar happened in the past?

□ Yes □ No Explain: _____

_____

Using the adjacent body charts, please circle all affected areas.

Have you been treated by a medical physician for this pain?

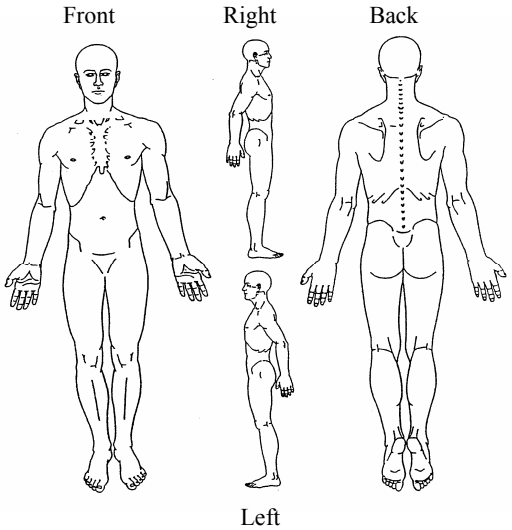
□ Yes □ No If so, where? _____

_____

Have you been treated by a chiropractor? □ Yes □ No

Clinic or Dr's Name: _____

Clinic Phone #: _____



Are you taking any of the following medication?

□ Nerve Pills □ Pain Killers (including aspirin) □ Muscle Relaxers □ Blood Thinners □ Tranquilizers

□ Other(s)_____

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

Y N Heart Attack/Stroke	Y N Heart Surg/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 Vernereal 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 Problems
Y N High/Low Blood Pressure	Y N Psychiatric problems	Y N Rheumatic Fever	Y N Severe/Frequent Headaches	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 Artificial Bones/Joints/Implants	

Family Health History:_____

_____

Please list any Medication Allergies? _____

Please List all Current Medications: _____

_____

_____

Do you take Supplements or Vitamins? □ Yes □ No Do you exercise? □ No □ Yes _____ hours per week

Are you wearing: □ Shoe lifts □ Inner soles □ Arch supports Are you dieting: □ No □ Yes since ____/____/_____

For Women: Are you taking Birth Control? □ Yes □ No

Are you nursing? □ Yes □ No Are you pregnant? □ No □ Yes How many weeks? _____

In Case of Emergency contact: _____ Rel. to patient: _____

Emergency Contact Phone: _____

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date _____/_____/_____

□ Adult Patient □ Parent or Guardian □ Spouse

_____

Dr. Notes: _____

_____

_____

_____

_____

_____