Booth Chiropractic & Acupuncture
Confidential Patient Data

PATIENT INFORMATION (IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST)

Name:______________________________ DOB:____________ Age:____
Address:______________________________ City/State/Zip: ______________________
Home#:__________________ Cell#:__________________ Other#:__________________
EMail:______________________________ ☐ Male ☐ Female
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Other:__________
Your Employer:______________________________ Occupation:____________
Name of Spouse or Nearest Relative:______________________________
Home#:__________________ Work#:__________________ Cell#:__________________

Referred to Booth Chiropractic by: ☐ Friend/Family Member - Name:__________________
☐ Passing By (location) ☐ Mail ☐ Flyer ☐ Church Bulletin ☐ Other:____________

INSURANCE INFORMATION

Payment for Services will be by: ☐ Cash ☐ Check ☐ Credit Card ☐ Health Insurance ☐ Automobile Insurance ☐ Worker's Compensation
Name of Insurance Company:______________________________
Insured's Employer:______________________________
Insured's Date of Birth:__________________ Employer's Phone#: ____________
Are you covered by more than one insurance company? ☐ Yes ☐ No
If yes, name of company:______________________________

MEDICAL/FAMILY HISTORY (S=Self M=Mother F=Father)

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

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	dislocated joints	☐	☐	☐	neck pain
☐	☐	☐	anemia	☐	☐	☐	epilepsy	☐	☐	☐	nervousness
☐	☐	☐	arthritus	☐	☐	☐	German measles	☐	☐	☐	numbness
☐	☐	☐	asthma	☐	☐	☐	headaches	☐	☐	☐	polio
☐	☐	☐	back pain	☐	☐	☐	heart trouble	☐	☐	☐	poor circulation
☐	☐	☐	bladder trouble	☐	☐	☐	reproductive disorders	☐	☐	☐	hepatitus
☐	☐	☐	bone fracture	☐	☐	☐	high blood pressure	☐	☐	☐	rheumatic fever
☐	☐	☐	cancer	☐	☐	☐	HIV/ARC	☐	☐	☐	rheumatism
☐	☐	☐	chest pain	☐	☐	☐	kidney disorder	☐	☐	☐	scarlet fever
☐	☐	☐	concussions	☐	☐	☐	bowel control loss	☐	☐	☐	serious injury
☐	☐	☐	convulsions	☐	☐	☐	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?
If yes, describe the condition:______________________________

Date of Last Physical Examination:______________________________

SOCIAL HISTORY

Tobacco usage	☐ None	☐ Light	☐ Moderate	☐ Heavy
Alcohol usage	☐ None	☐ Light	☐ Moderate	☐ Heavy
Drug usage	☐ None	☐ Light	☐ Moderate	☐ Heavy
Exercise	☐ None	☐ Seldom	☐ Occasional	☐ Heavy

1. What is your race?
(Please circle one)
White
African American
Asian
American Indian or Alaska Native
Native Hawaiian or Other Pacific Islander

2. What is your preferred language?
(Please circle one)
English
Spanish
French
German
Italian
Russian
Portuguese
Chinese
Japanese
Korean
Vietnamese

3. What is your preferred method of communication for private health care data?
(Please circle one)
Home Phone
Work Phone
Mobile Phone
E-Mail
Standard Mail

4. What is your smoking status?
(Please circle one)
Current Everyday Smoker
Current Someday Smoker
Former Smoker - Never Smoked

5. What is your ethnicity?
(Please circle one)
Hispanic or Latino
Not Hispanic or Latino

ACCIDENT INFORMATION

1.____________________ Date:________
2.____________________ Date:________
3.____________________ Date:________

SURGICAL HISTORY

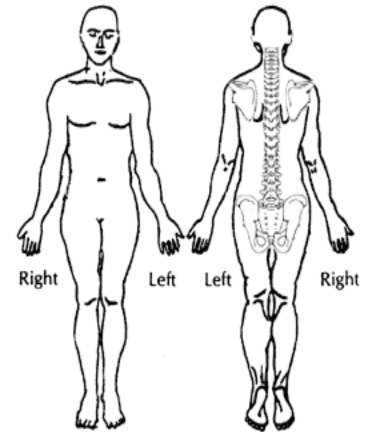
1.____________________ Date:________
2.____________________ Date:________
3.____________________ Date:________

DESCRIBE PRESENT MAJOR COMPLAINTS:

Please rate your pain for each complaint from 1-10 (10 for extreme pain)

1.____________________ Rating:________
2.____________________ Rating:________
3.____________________ Rating:________
4.____________________ Rating:________
5.____________________ Rating:________

circle area of pain



- Symptoms are worse in: ☐ Morning ☐ Afternoon ☐ Night
- Symptoms developed from: ☐ Job related injury ☐ Auto accident ☐ Accident ☐ Illness ☐ Unknown cause ☐ Gradual onset ☐ Other - ____________________
- Date when injury or symptoms occurred:__________ What happened?____________________
- Symptoms have persisted for:___ Hour(s) ___Day(s) ___Week(s) ___Month(s) ___Year(s)
- Symptoms/Complaints: ☐ Come and go ☐ Are constant
- Have you ever had this before? ☐ No ☐ Yes When?____________________
- If you were to guess, what do you think is causing your complaints?____________________
- Name and location of doctors previously seen for present symptom(s) or complaint(s):____________________
- Are you allergic to any medications? ☐ No ☐ Yes What kind?____________________
- Are you taking any medications? ☐ No ☐ Yes What kind?____________________
- Are you pregnant? ☐ Not applicable ☐ No ☐ Yes Date of last menstrual period:____________________

Please check the following activities that aggravate your condition:

☐ Bending ☐ Reaching ☐ Sitting ☐ Lying Down ☐ Coughing ☐ Straining at stool
☐ Standing ☐ Walking ☐ Lifting ☐ Turning head ☐ Sneezing

Please check the following activities that relieve your condition:

☐ Bending ☐ Reaching ☐ Sitting ☐ Lying Down ☐ Stretching
☐ Standing ☐ Walking ☐ Lifting ☐ Turning head

Please check any additional symptoms you may be experiencing:

☐ blurred vision ☐ buzzing in ears ☐ cold feet ☐ cold hands ☐ cold sweats ☐ concentration loss or confusion
☐ constipation ☐ depression or ☐ weeping spells ☐ diarrhea ☐ dizziness ☐ face flushed
☐ fainting ☐ fatigue ☐ fever ☐ headaches ☐ heavy head ☐ 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 & needles in arms ☐ pins & needles in legs ☐ ringing in ears ☐ shortness in breath
☐ stiff neck ☐ stomach upset ☐ other :__________

Patient's Signature:____________________ **Date:**__________