Patient Information Form

Photo ID Required

DATE:

PATIENT NAME..... PHONE .....

ADDRESS..... CITY ..... ZIP .....

DATE OF BIRTH..... AGE..... SOCIAL SECURITY NO .....

SINGLE // **MARRIED** EMAIL ADDRESS .....

NUMBER OF CHILDREN ..... NAMES & AGES .....

EMPLOYER ..... OCCUPATION ..... WORK PHONE .....

HEALTH INSURANCE CO. ..... SUBSCRIBERS NAME .....

SUBSCRIBERS DATE OF BIRTH ..... SOCIAL SECURITY NO .....

HAVE YOU HAD CHIROPRACTIC CARE BEFORE? **YES** // **NO** DOCTOR'S NAME? .....

WHEN WAS YOUR LAST VISIT THERE? ..... IS IT POSSIBLE YOU ARE PREGNANT? **YES** // **NO**

ARE YOU HERE BECAUSE OF AN: ON THE **JOB INJURY** // **AUTO ACCIDENT**? DATE OF ACCIDENT.....

WHAT SYMPTOMS DO YOU HAVE, WHERE DO YOU HURT, HOW BAD AND FOR HOW LONG?

.....

.....

.....

.....

.....

HAVE YOU EVER HAD ANY FALLS, BROKEN BONES, ACCIDENTS, OR INJURIES? YES // NO

MONTH/YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY FROM THIS ACCIDENT

HAVE YOU EVER HAD ANY SURGERIES? YES // NO

MONTH/YEAR	TYPE OF SURGERY	DESCRIBE REASON FOR SUGERY

PLEASE TURN THIS PAGE OVER AND COMPLETE THE FOLLOWING SIDE

LEE CHIROPRACTIC CENTER
3200 West 72nd Avenue,
Westminster CO 80030
303.429.2012

Patient Information Form

Side 2

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? YES // NO

NAME OF DRUG	DOSES PER DAY	WHAT ARE YOU TAKING THIS MEDICATION FOR?

PLEASE CHECK THE BOX IF YOU OR ANY MEMBERS OF YOUR IMMEDIATE FAMILY HAVE OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS

- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chest pains
- ☐ Cold feet
- ☐ Cold hands
- ☐ Cold sweats
- ☐ Concussion
- ☐ Constipation
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Face flushed
- ☐ Fainting
- ☐ Fatigue
- ☐ Gallbladder trouble
- ☐ Grating in neck
- ☐ Hayfever
- ☐ Head feels too heavy
- ☐ Headaches
- ☐ Heart attack
- ☐ Heart pain
- ☐ Heart palpitation
- ☐ High blood pressure
- ☐ Indigestion
- ☐ Inner tension
- ☐ Intestinal gas
- ☐ Irritability
- ☐ Kidney trouble
- ☐ Light bothers eyes
- ☐ Liver trouble
- ☐ Loss of balance
- ☐ Loss of memory
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Low back pain
- ☐ Menstrual cramps
- ☐ Menstrual irregularity
- ☐ Mid back pain
- ☐ Muscle spasms in neck
- ☐ Muscle spasms in mid back
- ☐ Muscle spasm in low back
- ☐ Neck pain
- ☐ Nervousness
- ☐ Nervous stomach
- ☐ Numbness in arms and hands
- ☐ Numbness in legs and feet
- ☐ Pain in legs and feet
- ☐ Pain in shoulders and arms
- ☐ Painful joints
- ☐ Rheumatic fever
- ☐ Ringing in the ears
- ☐ Shooting head pain
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Sleeping problems
- ☐ Stomach trouble
- ☐ Smoke cigarettes (how many per day?)
- ☐ Swollen ankles
- ☐ TB
- ☐ Thyroid trouble
- ☐ Tightness in shoulder muscles
- ☐ Tightness in the throat
- ☐ Twitching in face
- ☐ Ulcers

NOTE: It is understood and agreed the amount paid Dr. Lee is for examination and interpretation only and the X-ray negatives and records will remain the property of this office, being on file where they may be seen at any time while a patient of this office. Furthermore, I attest that all information given on this form is accurate to the best of my knowledge.

X SIGNATURE OF APPLICANT.....DATE.....

PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

LEE CHIROPRACTIC CENTER
3200 West 72nd Avenue,
Westminster CO 80030
303.429.2012