

# Welcome To Dallman Chiropractic

## Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name \_\_\_\_\_ S/S \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date \_\_\_\_\_  
First Name Middle Initial Last Name

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  Female  Male Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Are you:  Single  Married  Widowed  Divorced No. Of Children \_\_\_\_\_

Your Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's or Parents Name \_\_\_\_\_ Workplace \_\_\_\_\_ Work Phone # \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone # \_\_\_\_\_

Name of person responsible for this account? \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Insurance Information:

Name of Insured \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

**Office Policies:** I, the undersigned certify that I (or my dependent) have insurance coverage, and assign all insurance payable to me for services rendered. I hereby authorize the doctor to release all the information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

If I am accepted as a patient at the Dallman Chiropractic Office I agree to pay for all services, including services not covered by my insurance company. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.

**Consent To Treat:** I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. I now authorize Dr. Dallman to proceed with any necessary treatment. I have read Dr. Dallman's office policies and consent to treat information, and I agree with them by signing below:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Patient's Name \_\_\_\_\_

Today's Date \_\_\_\_\_

### Patient Condition Worksheet

*Please Circle All*

**Reason for Visit:** Headaches Neck Pain Neck Stiffness Allergies Shoulder/Arm Pain Upper-Back Pain  
Mid-Back Pain Low-Back Pain Hip/Pelvis Pain Sinus Problems Asthma Stomach Pain Chest Pain  
Numbness Arthritis Sciatica Stress Other: \_\_\_\_\_

**When did your present condition begin?** Gradual Onset Date: \_\_\_\_\_

**What happened to cause your present symptom:** Auto Accident Work Accident Home Accident Gradual Onset

**Explain:** \_\_\_\_\_

**Have you ever had these symptoms before?** No Yes - Date: \_\_\_\_\_

**What time of day are your symptoms worse?** Morning Afternoon Evening All of the above (constant pain)

**What time of day are your symptoms better?** Morning Afternoon Evening None of the above (constant pain)

**Is your condition getting progressively worse?** Yes No Unknown

**Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain)** \_\_\_\_\_

**Type of pain:** Sharp Dull Throbbing Aching Shooting Burning Tingling Cramps Other

**How often do you have this pain?** Constant Comes and goes

**Does your pain interfere with:** Work Sleep Daily Activities

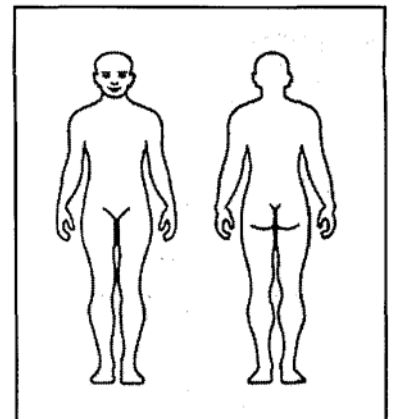
**What makes your problem worse** Standing Sitting Bending Twisting Lifting Lying Down

**Is there anything that relieves the problem** Yes No **If Yes describe** \_\_\_\_\_

**If no what have you tried** \_\_\_\_\_

**Mark X on the picture where your problem is:**

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Patient's Name \_\_\_\_\_

Today's Date \_\_\_\_\_

### Health History Worksheet

Have you had any previous accidents? No Yes \_\_\_\_\_

Have you had any previous hospitalizations? No Yes \_\_\_\_\_

Have you had any fracture/broken bones? No Yes \_\_\_\_\_

Are you taking any medications/supplements? No Yes \_\_\_\_\_

Women Only: Are you pregnant or is there any possibility you may be pregnant? Yes No Uncertain

Have you seen another doctor for this condition? No Yes \_\_\_\_\_

Did this doctor recommend any treatment? No Yes \_\_\_\_\_

#### Please circle if you have had any of the following:

- |                    |                     |                    |                      |                    |
|--------------------|---------------------|--------------------|----------------------|--------------------|
| AIDS/HIV           | Chicken Pox         | High Cholesterol   | Pneumonia            | Thyroid Problems   |
| Alcoholism         | Diabetes            | Kidney Disease     | Polio                | Tuberculosis       |
| Allergies          | Emphysema           | Liver Disease      | Prostate Problems    | Tumors/Growths     |
| Anemia             | Epilepsy            | Measles            | Psychiatric Care     | Typhoid Fever      |
| Appendicitis       | Goiter              | Mono               | Rheumatoid Arthritis | Ulcers             |
| Asthma             | Gout                | Multiple Sclerosis | Rheumatic Fever      | Vaginal Infections |
| Bleeding Disorders | Heart Disease       | Mumps              | Scarlet Fever        | Venereal Disease   |
| Bronchitis         | Hepatitis           | Osteoporosis       | Stroke               | Whooping Cough     |
| Cancer             | High Blood Pressure | Parkinson's        | Suicide Attempt      | Other              |

Do you play any sports or exercise? No Yes \_\_\_\_\_

How many hours do you sleep at night? \_\_\_\_\_ How many hours a week do you work? \_\_\_\_\_

Do you drink alcohol? No Yes \_\_\_\_\_ Do you smoke? No Yes \_\_\_\_\_

Anything else doctor should know about? No Yes \_\_\_\_\_

#### Significant Family Medical History

Did your father have any health problems? No Yes \_\_\_\_\_

Did your mother have any health problems? No Yes \_\_\_\_\_

Did your brother(s) have any health problems? No Yes \_\_\_\_\_

Did your sister(s) have any health problems? No Yes \_\_\_\_\_

Did your grandpa have any health problems? No Yes \_\_\_\_\_

Did your grandma have any health problems? No Yes \_\_\_\_\_