

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 _____

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 _____ Date of Birth _____

Insurance Company _____ Policy # _____

Office Policies:

I, the undersigned certify that I (or my dependent) have insurance coverage, and assign all insurance benefits, otherwise 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

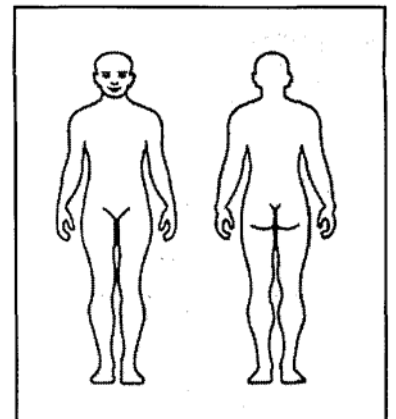
What makes your problem worse Standing Sitting Bending Twisting Lifting Lying Down

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 _____

