Gallipolis Chiropractic Center

990 Second Ave. Gallipolis, Ohio 45631

Name: _____ _____
First MI Last SSN

Address: _____ Home Phone: _____

_____ Cell Phone: _____
City ST Zip

Birthdate: _____ Age _____ Preferred pronoun: _____

Marital Status: M S D Other E-Mail: _____

Patient Employer: _____ Phone number: _____

Spouse's name: _____ Phone number: _____

In Case of Emergency Contact: _____
First name Last name Relationship

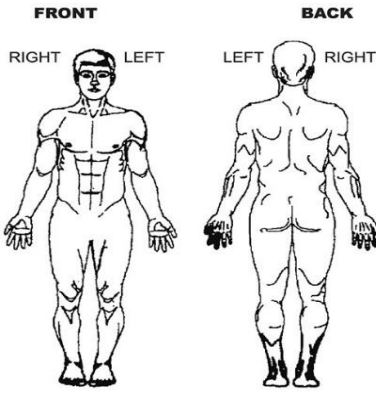
Home Phone: _____ Cell Phone: _____

How did you hear about us? _____

Is condition due to an accident: ☐ Yes ☐ No Date: _____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other Attorney Name: _____

Mark an X on the picture where you have pain or discomfort



When did you hurt yourself? _____

How did you hurt yourself? _____

How often do you have this pain? _____

What is your pain level on a scale of 1 (least pain) to 10 (severe pain)_____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramp ☐ Stiffness ☐ Swelling

Does the pain interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Is it painful to: ☐ Sit ☐ Stand ☐ Walk ☐ Bend ☐ Lay Down

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Gallipolis Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I understand that Chiropractic adjustments are usually beneficial and seldom cause any problems, but there are risks to treatment. Risks include but are not limited to: fractures, disc injuries, strokes, dislocations and sprains. By signing below I verify that I understand the above statements.

_____ _____
Signature of Patient or Parent **Printed Name**

Relationship to patient: _____ **Date:** _____

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name of other Doctors who have treated your condition: _____

Date of Last: Physical Exam _____ Spinal X-ray _____ Blood Test _____

Spinal Exam _____ Chest X-ray _____ Urine Test _____

Dental X-ray _____ MRI, CT-Scan _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Circle to indicate if you have had any of the following:

AIDS/HIV	Diabetes	Measles	Rheumatic Fever
Alcoholism	Emphysema	Migraines	Scarlet Fever
Allergy Shots	Epilepsy	Miscarriage	Stroke
Anemia	Fractures	Mononucleosis	Suicide Attempt
Anorexia	Glaucoma	Multiple Sclerosis	Thyroid Problems
Appendicitis	Goiter	Mumps	Tonsillitis
Arthritis	Gonorrhea	Osteoporosis	Tuberculosis
Asthma	Gout	Pacemaker	Tumors, Growths
Bleeding disorder	Heart Disease	Parkinson's	Typhoid fever
Breast Lump	Hepatitis	Pinched Nerve	Ulcers
Bronchitis	Hernia	Pneumonia	Vaginal Infections
Bulimia	Herniated Disc	Polio	Venereal Disease
Cancer	Herpes	Prostate problems	Whooping Cough
Cataracts	High Cholesterol	Prosthesis	Other: _____
Chemical dependency	Kidney Disease	Psychiatric care	_____
Chicken Pox	Liver Disease	Rheumatoid Arthritis	

Exercise	Work Activity	Habits	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day _____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason _____

Injuries/Surgeries you have had	Description	Date
Falls/Head Injuries		
Broken Bones		
Surgeries		

Medications/Vitamins: _____

Allergies _____

By signing below, I certify all information is true and correct to the best of my knowledge.

_____ _____ _____

Patient or Parent Signature **Printed Name** **Date**