# PRE-ADULT PATIENT FORM

DATE _____ PATIENT NUMBER _____

*PATIENT INFORMATION*

NAME _____ DATE OF BIRTH _____

SSN _____ PHONE NUMBER _____

ADDRESS _____

_____

REFERRED BY _____ STUDENT: YES NO

*PARENT / GUARDIAN INFORMATION*

NAME OF PARENTS / GUARDIAN _____

PHONE NUMBER _____ WORK NUMBER _____

ADDRESS (IF DIFFERENT) _____

_____

| MAJOR COMPLAINTS: | *PAIN* | *NUMBNESS* | *TINGLING* |
|---|---|---|---|
| HEAD | ( ) | ( ) | ( ) |
| NECK | ( ) | ( ) | ( ) |
| UPPER BACK | ( ) | ( ) | ( ) |
| MID BACK | ( ) | ( ) | ( ) |
| LOW BACK | ( ) | ( ) | ( ) |
| SHOULDER | ( ) | ( ) | ( ) |
| ARM | ( ) | ( ) | ( ) |
| HAND | ( ) | ( ) | ( ) |
| BUTTOCK | ( ) | ( ) | ( ) |
| HIP | ( ) | ( ) | ( ) |
| LEG | ( ) | ( ) | ( ) |
| FOOT | ( ) | ( ) | ( ) |

*IS CONDITION DUE TO AN AUTO ACCIDENT ( ), FALL ( ), OTHER ( )*

ILLNESSES: *HAVE YOU EVER OR ARE YOU NOW EXPERIENCING ANY OF THE FOLLOWING?*

| | Y | N | | Y | N |
|---|---|---|---|---|---|
| ASTHMA | ( ) | ( ) | HEART | ( ) | ( ) |
| SINUS TROUBLE | ( ) | ( ) | HIV / AIDS | ( ) | ( ) |
| DIABETES | ( ) | ( ) | CANCER | ( ) | ( ) |
| EPILEPSY | ( ) | ( ) | POLIO | ( ) | ( ) |
| KIDNEY TROUBLE | ( ) | ( ) | EMOTIONAL DISORDER | ( ) | ( ) |
| MENTAL DISORDER | ( ) | ( ) | OTHER | ( ) | ( ) |

**HEALTH HISTORY:** *HAVE YOU EVER OR ARE YOU NOW SUFFERING ANY OF THE FOLLOWING HEALTH PROBLEMS?*

| | Y | N | | Y | N |
|---|---|---|---|---|---|
| HEADACHES | ( ) | ( ) | BREATHING TROUBLE | ( ) | ( ) |
| ALLERGIES | ( ) | ( ) | FATIGUE | ( ) | ( ) |
| EAR PROBLEMS | ( ) | ( ) | IRRITABILITY | ( ) | ( ) |
| SLEEPING PROBLEMS | ( ) | ( ) | HYPERACTIVITY | ( ) | ( ) |
| FREQUENT COLDS | ( ) | ( ) | FREQUENT FLU | ( ) | ( ) |
| BLOODY NOSE | ( ) | ( ) | MENINGITIS | ( ) | ( ) |
| RASHES | ( ) | ( ) | BED WETTING | ( ) | ( ) |
| DIGESTIVE PROBLEMS | ( ) | ( ) | OTHER | ( ) | ( ) |

HAVE YOU EVER FALLEN OVER THREE FEET? _____

ARE YOU ACCIDENT PRONE? _____

PLEASE LIST PREVIOUS / PRESENT BROKEN BONES _____

PLEASE LIST PREVIOUS / PRESENT SPRAINS _____

**MEDICAL HISTORY:**

HAVE YOU EVER SEEN A CHIROPRACTOR? _____ LAST VISIT _____

DO YOU HAVE A FAMILY PHYSICIAN? _____ WHO? _____

HAVE YOU EVER BEEN HOSPITALIZED? _____

HAVE YOU HAD ANY SURGERIES? _____

**INSURANCE?**

POLICY HOLDER _____

COMPANY _____

POLICY NUMBER _____ GROUP NUMBER _____

*I UNDERSTAND AND AGREE THAT THE HEALTH AND ACCIDENT POLICIES ARE AN ARRANGEMENT BETWEEN AND INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THIS OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AGREE THAT ANY SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICE RENDERED ME WILL BE IMMEDIATELY DUE AND CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICE RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.*

PARENT / GUARDIAN SIGNATURE _____

DATE _____