Pursuit Chiropractic *Please complete - print - circle areas of concern and sign. Bring with you to the appointment*

Patient Information

Name: ____

Address: ______________________________ Apt. #: __________

City: ______________ State: ______ Zip:________ SSN: ______________

Date of Birth :__________ Age: _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: __________________ Cell phone:__________________

Email address: ____

Employer: ______________________ Work Phone:______________

Please describe your occupation: ______________________________

Spouse Name: ______________________ Date of Birth: __________

Emergency Contact: __________________ Phone: ______________

Who referred you to our office? ______________________________

Have you had chiropractic care before? ☐ Yes ☐ No If yes, where?______________

Insurance Information

1.) Primary Insurance Company: ______________________________

ID or Contract #: ______________________ Group#:______________

Subscriber's Name: ______________________ Date of Birth: __________

Subscriber's Address: ______________________________________

City: ______________ State: ______ Zip: ________ Phone:__________

2.) Secondary Insurance Company: ______________________________

ID or Contract #: ______________________ Group #: ______________

Subscriber's Name: __________ ______________ Date of Birth:__________

Subscriber's Address: ______________________________________

City: ______________ State: ______ Zip: ________ Phone: __________

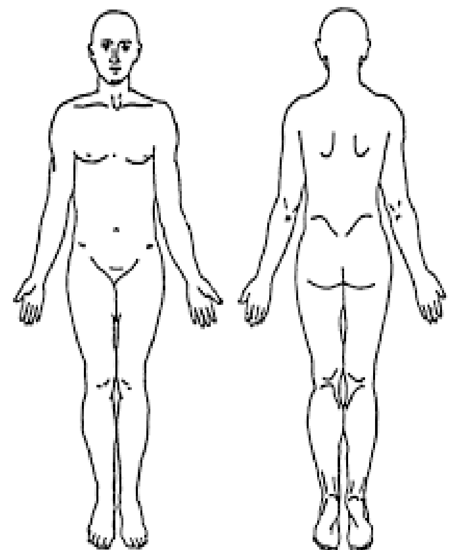
Reason for Visit

Are you coming to see us as a result of:

☐ An auto accident ☐ A work-related injury ☐ A personal injury

Other doctors seen for this condition: ______________

Circle the areas to the right where you have pain or other symptoms ⟶



Please describe your symptoms:______________________

____

____

When did your symptoms start? ______________________

Have you had similar conditions in the past? ______________

PLEASE COMPLETE BOTH SIDES

Is your primary complaint worse in the: ⇨ a.m. ⇨ p.m. ⇨ same

Rate the intensity of your pain: (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

Is your pain worse when: Sitting Standing Lying down

What helps relieve your discomfort? Ice Heat Rest Movement Nothing

Please check any of the following that give you difficulty:

☐ Headache	☐ Loss of balance	☐ High blood pressure	☐ Menstrual cramps & pain
☐ Shooting head pains	☐ Ringing in ears	☐ Low blood pressure	☐ Menstrual irregularity
☐ Sinus trouble	☐ Blurred vision	☐ Anemia	☐ Bladder irregularity
☐ Loss of smell	☐ Lights bother eyes	☐ Stomach trouble	☐ Bowel irregularity
☐ Allergies	☐ Neck pain	☐ Nerves/nervousness	☐ Diabetes
☐ Hayfever	☐ Muscle spasms in neck	☐ Inner tension	☐ Cancer
☐ Asthma	☐ Grinding in neck	☐ Irritability	☐ Sleeping problems
☐ Loss of taste	☐ Tightness of shoulders/arms	☐ Gallbladder trouble	☐ Painful joints
☐ Thyroid trouble	☐ Pain in shoulders/arms	☐ Indigestion	☐ Swollen joints
☐ Twitching of face	☐ Pins /needles in arms/hands	☐ Intestinal gas	☐ Pins & needles in legs
☐ Loss of memory	☐ Cold hands	☐ Low back pain	☐ Swollen ankles
☐ Fatigue	☐ Numbness in arms/hands	☐ Ulcers	☐ Cold feet
☐ Depression	☐ Shortness of breath	☐ Numbness in legs/feet	☐ Pains in legs/feet
☐ Dizziness	☐ Mid back pain	☐ Constipation	☐ Other___________________
☐ Fainting	☐ Heart attacks	☐ Kidney trouble	☐ Other___________________

Have you ever had any falls, auto accidents, or injuries? ☐ Yes ☐ No If yes, please explain:

Month/Year:____________ Type of Accident:____

Describe Injury: ____

Month/Year:____________ Type of Accident:____

Describe Injury: ____

Have you ever had surgery? ☐ Yes ☐ No If yes, please explain:

Month/Year: ____________ Type of surgery: ____

Month/Year: ____________ Type of surgery: ____

Are you presently taking medication or vitamins? ☐ Yes ☐ No If yes, please list:

Name of drug: ______________________________ Name of drug: ______________________________

Name of drug: ______________________________ Name of drug: ______________________________

Do you smoke? ☐ Yes ☐ No **Drink alcohol?** ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently

What exercise programs do you currently participate in? ________________________________

Family History

Do any of your blood relatives have any of the following (list relation to you):

☐ Diabetes	Relation: ____________________	☐ Cancer	Relation: ____________________
☐ Stroke	Relation: ____________________	☐ Heart Problems	Relation: ____________________
☐ Scoliosis	Relation: ____________________	☐ Back Problems	Relation: ____________________
☐ Headaches	Relation: ____________________	☐ Ulcers	Relation: ____________________

X ____ ________________________

Patient/Parent/Guardian Signature **Date**