Gilmore Chiropractic

Patient Information ***Please Print***

Name______________________________Date___________SS#_________________________________

Address_________________________________City________________State_______Zip____________

Sex: ( )M - ( )F Birthday_______________

Home Phone(___)__________Cell(___)____________Work(___)_________E-mail______________________

Employer____________________________Occupation__________________________#Years__________

Business Address________________________ City______________ State________ Zip______________

Spouse or Parent's Name__________________________Birthday_________Phone(___)______________

Emergency Contact________________________ Phone (___)____________Relation___________________

Whom may we thank for referring you to us?____

Did you see our Newspaper Flyer? ________Yellow Page Ad?_________ Other? ____________________

Name of local primary Physician_________________________ May we contact them_________________

Insurance Information

Name of insured_________________________ Relationship to Patient_____________________________

Birthdate_________ SS#______________ Employer_________________________Phone(___)___________

Address_______________________________City_______________State_______Zip_________________

Insurance Co.________________Phone(___)___________Group#_____________Employer#___________

Insurance Co Address__________________________City______________State_________Zip_________

Deductible Amt.___________ How much has been used?_____________ Max Annual benefit__________

Symptoms

Main complaint____________________ How bad?_________________ How Often?___________________

When did it start?_____________________ Getting worse? _______________Getting better?____________

What activity bothers it the most? ____

When is it at its best? __________________________When is it at its worse? _________________________

Rate the pain – (0 is pain free – 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10

Other Chiropractors?____________________________ Positive Experience?__________________________

Secondary Complaint____

Health History

Please circle all that apply

AIDS/HIV	Allergy Shots	Anemia	Anorexia	Cataract	Chicken pox	Liver dx	Parkinson's
Breast lump	Bronchitis	Bulimia	Cancer	Goiter	Gonorrhea	Pacemaker	Tyroid
Emphysema	Epilepsy	Polio	M.S.	Kidney dx	Gout	Stroke	Whooping chough
Hepatitis	Hernia	Herpes	Glaucoma	Osteoporosis	Mumps	Bleeding	Chronoic fatigue
Migraines	Miscarriage	Mono	Prosthesis	Rheumatoid	Implants	Diabetes	Hi blood pressure
Pneumonia	Fractures	Prostate	Typhoid	Asthma	Ulcers	Heart dx	Fibromyalgia
Tonsillitis	Tuberculosis	Tumors	V.D.	Depression	Arthritis	Measles	Herniated disc

Appendicitis Hi cholesterol Other____

Woman –How many children?______Pregnant?______ last menstrual cycle___________Nursing?________

Taking birth control?______________

Previous surgeries and dates?____

List all medications or supplements you are taking____

How much do you smoke per day?________________drink per week?_______________________________

All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous.I authorize office to release any information pertaining to my treatment to third party payers or other health care provider.I authorize and request my insurance company to pay directly the chiropractor any benefits payable to me.I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.

Please Sign__________________________________Date____