FLETCHER CHIROPRACTIC CENTER

PATIENT INFORMATION
PLEASE PRINT AND COMPLETE

(208) 939-3000

PLEASE CHECK THE TYPE OF CARE DESIRED: ☐ TEMPORARY RELIEF ☐ LASTING CORRECTION
CHECK HERE ☐ IF YOU WOULD LIKE THE DOCTOR TO RECOMMEND THE BEST TYPE OF CARE FOR YOU.

PATIENT NAME ______________________ TODAY'S DATE ______________

ADDRESS ______________________ CITY __________ STATE ________ ZIP ________

DATE OF BIRTH ______________ HOME PHONE ______________________

EMPLOYER ______________________ WORK PHONE ______________
SOCIAL SECURITY NO. ______________________ AGES OF CHILDREN ______________

CHECK IF YOU ARE: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

NAME OF SPOUSE ______________________ SPOUSE EMPLOYER ______________
WORK PHONE ______________________ SPOUSE SOC. SECURITY NO. ______________

PERSON RESPONSIBLE FOR BILL: ☐ SELF ☐ EMPLOYER ☐ INSURANCE ☐ OTHER

AS A COURTESY, OUR OFFICE WILL BILL YOUR PRIMARY INSURANCE FOR YOU. IF YOU HAVE A SECONDARY INSURANCE, THIS WILL BE YOUR RESPONSIBILITY TO BILL.

INSURANCE COMPANY ______________________
ADDRESS ______________________
____
SUBSCRIBER NAME ______________________ D.O.B. ______________
POLICY/GROUP # ______________________
MEMBERSHIP # ______________________

REFERRED BY: ☐ RELATIVE ☐ FRIEND ☐ CO-WORKER ☐ DOCTOR ☐ YELLOW PAGES ☐ OTHER
NAME OF REFERRING PERSON ______________________

CHIROPRACTORS CONSULTED IN THE PAST? NAME ______________________
DATES CONSULTED ______________ FOR WHAT PROBLEM? ______________________

CURRENT MEDICAL DOCTOR OR OTHER: ______________________
ADDRESS ______________________ PHONE NO. ______________

OTHER FAMILY MEMBERS SEEN AT THIS OFFICE __________ RELATIONSHIP ______________

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY (OUTSIDE OF YOUR HOUSEHOLD)

NAME ______________________ RELATIONSHIP ______________
ADDRESS ______________________ PHONE NO. (______) ______________

* * * * * * * * *

The above information is true and correct to the best of my knowledge. I accept and acknowledge utlimate responsibility for all charges I incur in this office. All fees are payable at the time X-rays, examinations, and treatments are received, unless other arrangements are made in advance. I hereby authorize Fletcher Chiropractic Center to release to my insurance carrier any information required for my claim.

PATIENT SIGNATURE ______________________ DATE ______________

– OVER, PLEASE –

If you are in pain, mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, ETC.

COMPLETE THESE DIAGRAMS

MAJOR COMPLAINT
(Please describe only your major problems).

____
____
____
____
____
____
____
____
____
____
____
____
____

How and **When** did this condition develop?(What caused it? How did it start?)______________________________

____

Have you ever had this problem or similar problem before? If yes, please explain:______________________________

____

Have you received any treatment for this condition? If yes, when, and where and what were your results?______________________________

____

Has this problem been getting better, worse, or staying the same?______________________________

Is there anything you do that makes your condition worse?______________________________

____

How has this condition affected your life?

A. Home life______________________________

B. Occupational life______________________________

C. Recreational life______________________________

D. Rest and sleep______________________________

Have you ever been in an automobile accident? ___Past year ___Past 5 years ___Over 5 years ____Never

ANY ACCIDENTS, FALLS, ETC., THAT MIGHT HAVE CAUSED YOUR PROBLEM?______________________________

Are you pregnant? ___Yes ___No

DRUGS YOU TAKE NOW: ___Nerve pills ___Pain Killers ___Muscle Relaxers ___Insulin ___Birth Control Pills

___Other (please list)______________________________

Have you ever had any surgery?______________________________