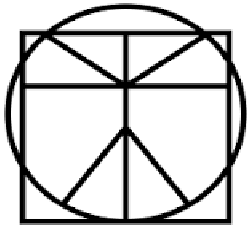

Independence Chiropractic
Tel: (337) 984-9276
Fax: (337) 984-9012
Website: www.drjohn1.com

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:	**Date:**
Address: **City:** **State:** **Zip:**	
Home phone:	**Work phone:**
Cell phone:	**Email address:**
Best time/place to contact you:	
Date of birth:	**Age:**
No. of children:	**Pregnant? Yes ☐ No ☐**
Height:	**Weight:**
Marital status: M S W D	**Spouse/guardian name:**
Occupation:	
Employer's name & address:	
Spouse's Occupation/Employer:	
Name of person responsible for account:	
Who may we thank for referring you? ____	

Addressing What Brought You Into This Office:

*If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the **"General Health History"**.*

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?
____
____

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgeries)

Type of Surgery	When? (Year)	Were you satisfied with the results?
1		
2		
3		
4		

Do you wear orthotics or heel lifts? Yes ☐ No ☐

Current Medicines and Supplements *(Attach your list of medications)*

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

____
____

If dietary changes are indicated would you be willing to make changes in your diet?	Yes ☐ No ☐ Maybe ☐
If specific exercises would help would you consider adding them to your program?	Yes ☐ No ☐ Maybe ☐
If reducing stress would help you would you like to know ways to reduce stress?	Yes ☐ No ☐ Maybe ☐

The type of diet I usually follow is classified as: ____

Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

☐ Allergy	☐ Arteriosclerosis	☐ Arthritis	☐ Asthma	☐ Back Pain	☐ Constipation
☐ Depression	☐ Diabetes	☐ Diarrhea	☐ Gall Bladder Problems	☐ Convulsions	☐ Headaches
☐ Heart Attack	☐ High Blood Pressure	☐ Irregular Periods	☐ Low Blood Sugar	☐ Migraines	☐ Neck Pain
☐ Sinus Problems	☐ Thyroid Problems				

Other (please explain) ____
____

Stressors

Because one or more types of stress is the underlying cause of ***All ILLNESS***. Which area(s) of stress do you believe are the most responsible for your condition?

1. Physical stress (injuries, posture, etc.)
   a. ____
   b. ____
2. Chemical stress (toxins, foods, etc.)
   a. ____
   b. ____
3. Mental/emotional stress (worry, anxiety, etc.)
   a. ____
   b. ____

Is there anything else that you can tell me that might help me to help you?

____
____

_____ I consent to a professional and complete chiropractic examination. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: ____ Date: ________________________

Signature: ____