American Family Chiropractic Center

5248 Courseview Drive Mason, Ohio 45040-2302

Office: (513) 398-6300 **Fax:** (513) 398-6363

Thank you for downloading the Patient History Form.

Now that you have the Form, you can fill it out at your leisure and find,
check all the information required before coming to the office.

We recommend the Patient History Form be faxed to our office prior to your visit.

This is our Fax number: **(513) 398-6363**

By sending us your information, the amount of time spent filling out,
signing and checking forms is greatly reduced.

We are looking forward to seeing you soon.
The Staff of American Family Chiropractic Center

PATIENT INFORMATION

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Date:_________________________

S. S. ID#:_____________________________

Patient's Name:______________________________
Last Name

_____________________ __________
First Name Middle Initial

Address: ________________________________
City: __________________________________
State: _______________ Zip: ______________
E-mail: _________________________________
Sex: M F Age: ___________
Birthdate: ____________________________

Married ( ) Widowed ( ) Single ( ) Minor ( )
Separated ( ) Divorced ( )
Partnered for _____ years

Occupation: _____________________________
Patient Employer/School __________________
Employer/School Address:_________________
____
Employer/School Phone: __________________
Spouse's Name: _________________________
Spouse's Employer: ______________________

Whom may we thank for referring you?
____

INSURANCE

Who is responsible for this account? ____________________
Relationship to Patient: __________________________
Insurance Company: ___________________________
Group #:_______________________________________
Is patient covered by additional Insurance? YES NO
Subscriber's Name: _____________________________
Birthdate: _____________ SS# ___________________
Relationship to Patient: __________________________
Insurance Company: ____________________________
Group #:_______________________________________

Assignment and Release

I certify that I, and/or my dependant (s), have insurance coverage with ____ and assign directly to Dr. ______________________________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am
financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is complete or one year from the date signed below.

____
Signature of Patient, Parent, Guardian, or Personal Representative

____
Print Name of Patient, Parent, Guardian, or Personal Representative

___________________ _________________________
Date Relationship to Patient:

PHONE NUMBERS

Home Phone (____) ___________________
Cell Phone: (____) _____________________
Best time and place to reach you:
____

IN CASE OF EMERGENCY CONTACT

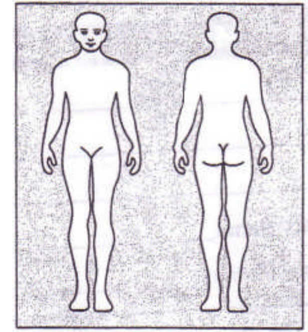
Name: ______________________________
Relationship: _________________________
Home Phone: (____) ___________________
Work Phone: (____) ___________________

ACCIDENT INFORMATION

Is condition due to an accident? YES NO
Date: _________________________________
Type of accident: ( ) Auto ( ) Work ( ) Home
Other _________________________________
To whom have you made a report of your accident?
( ) Auto Insurance ( ) Employer ( ) Worker Comp
( ) Other
Attorney name (if applicable)

____

PATIENT CONDITION



Reason for visit: ____

When did symptoms appear? ______________________________________

Is this condition getting progressively worse? ( ) YES ( ) NO

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)
____

Type of pain: ( ) Sharp ( ) Dull ( ) Throbbing ( ) Numbness ( ) Aching
( ) Shooting ( ) Burning ( ) Tingling ( ) Cramps ( ) Stiffness ( ) Swelling
( ) Other

How often do you have this pain? ____

Is it constant or does it come and go? ______________________________________

Does it interfere with your ( ) work ( ) Sleep ( ) Daily Routine ( ) Recreation

Activities or movements that are painful to perform ( ) Sitting ( ) Standing ( ) Walking ( ) Bending
( ) Lying down

HEALTH HISTORY (Part 1)

What treatment have you already received for your Condition?
( ) Medications ( ) Surgery ( ) Physical Therapy ( ) Chiropractic Care ( ) None
( ) Other ____

Name and address of other doctor(s) who have treated you for your condition:
____

Date of Last Physical Exam __________ Spinal X-ray __________ Blood Test __________
Spinal Exam __________ Chest X-ray __________ Urine Test __________ Dental X-ray __________
MRI, CT-Scan, Bone Scan __________

Place a mark on “Yes” or “NO” to indicate if you have any of the following:

AIDS/HIV YES NO	Diabetes YES NO	Migraine Headaches YES NO	Scarlet fever YES NO
Alcoholism YES NO	Emphysema YES NO	Miscarriage YES NO	Stroke YES NO
Allergy Shots YES NO	Epilepsy YES NO	Mononucleosis YES NO	Suicide Attempt YES NO
Anemia YES NO	Fractures YES NO	Multiple Sclerosis YES NO	Thyroid Problems YES NO
Anorexia YES NO	Glaucoma YES NO	Mumps YES NO	Tonsillitis YES NO
Appendicitis YES NO	Goiter YES NO	Osteoporosis YES NO	Tuberculosis YES NO
Arthritis YES NO	Gonorrhea YES NO	Pace Maker YES NO	Tumors, Growths YES NO
Asthma YES NO	Heart Disease YES NO	Parkinson’s Disease YES NO	Typhoid Fever YES NO
Bleeding Disorders YES NO	Hepatitis YES NO	Pinched Nerve YES NO	Ulcers YES NO
Breast Lump YES NO	Hernia YES NO	Pneumonia YES NO	Vaginal Infections YES NO
Bronchitis YES NO	Herniated Disc YES NO	Polio YES NO	Venereal Disease YES NO
Bulimia YES NO	Herpes YES NO	Prostrate Problem YES NO	Whooping Gough YES NO
Cancer YES NO	High Cholesterol YES NO	Prosthesis YES NO	Other
Cataracts YES NO	Kidney Disease YES NO	Psychiatric Care YES NO	
Chemical Dependency YES NO	Liver Disease YES NO	Rheumatoid Arthritis YES NO	
Chicken Pox YES NO	Measles YES NO	Rheumatic Fever YES NO	

HEALTH HISTORY (Part 2)

EXERCISE	WORK ACTIVITY	HABITS
( ) None	( ) Sitting	( ) Smoking Packs/Day_______
( ) Moderate	( ) Standing	( ) Alcohol Drinks/Week ______
( ) Daily	( ) Light Labor	( ) Coffee/Caffeine Drinks Cups/Day __
( ) Heavy	( ) Heavy labor	( ) High Stress Level Why _____________

Are you Pregnant? YES NO Due Date: ______________________

Injuries/Surgeries you have had:	Description	Date
FALLS		
HEAD INJURIES		
BROKEN BONES		
DISLOCATIONS		
SURGERIES		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

Pharmacy Name: ____

Pharmacy Phone: (____) ____________________