TAIRA CHIROPRACTIC

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PATIENT INFORMATION FORM

(***Office Use Only***) Patient Number _____ Date____/____/____ Claim Number _____

First Name_____MI_____Last Name_____

Home Phone#( )_____ Cell Phone#( )_____ Work Phone#( )_____

Address_____City_____State_____Zip_____

Birthday____/____/____ Sex_____ Marital Status (S M W D) Spouse's Name_____ #of Children____

Social Security #_____ Employer_____ Occupation_____

In Case of Emergency Notify_____ Relationship_____ Phone#( )_____

Email:_____ *How did you hear about us/Referred by*:_____

Major Complaint:_____

Condition is due to: (circle) Auto Accident Work Injury Slip/Fall Unknown Cause other_____

When did the complaint happen:_____ How frequent does it occur:_____

Have you had this complaint before?____ If yes, when & how?_____

The complaint is: (circle) Improving / Getting Worse / Same /// Constant or Intermittent (comes & goes)

The complaint is worse: (circle) In the Morning / End of Work / At Night / During Sleep other:_____

Does the pain travel? If yes, to what area?_____

What Aggravates the condition: (circle) Standing Walking Sitting Lying Bending Lifting Twisting Coughing other_____

What Relieves the condition: _____

Has it affected your sleep?_____ What position do you sleep in: (circle) Back Right Side Left Side Stomach

Has it affected your work?_____ What position are you in majority of the work day: (circle) Standing Sitting Both

Have you seen another doctor for this condition?_____ If yes, treatment provided _____

Have you ever seen a Chiropractor?_____ If yes, what Dr. & when _____