

ABOUT THE PATIENT

Name _____ Today's Date _____ Birthdate _____ Age _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____ Gender ☐ M
☐ F
 Significant Other's Name _____ Kid's Names and Ages _____
 Your Employer _____ Type of Work _____
 e-Mail Address _____ Have you been to a chiropractor before? ☐ No
☐ Yes
 Emergency Contact _____ ph # _____
 Name of Medical Doctor(s) _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize **Thornapple River Chiropractic** to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- ~~Person responsible for this account if other than the patient?~~

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____

2. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____

3. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____

4. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____

5. Does your condition affect: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ _____

6. What makes it better? _____

7. What makes it worse? _____

8. What Doctor's have you seen for this? _____

9. Type of treatment: _____

Are you pregnant?

☐ Yes ☐ No

