

**GREENE CHIROPRACTIC CENTER
2100 KANSAS
GREAT BEND, KANSAS 67530**

PATIENT INTRODUCTION FORM AND HEALTH HISTORY

Name _____

Current Address _____ City _____ State _____ Zip _____

Home Phone _____ Email _____ Work Phone _____

Place of Employment _____ Full Time Part Time None Occupation _____

Date of Birth _____ Age _____ Social Security _____ Sex: M F

Marital Status (circle one) M S W D Name of Spouse _____

Under 19 Parent/Guardian _____ Student: Full Time Part Time None

Number and ages of children _____

Insurance Co _____ Policy Holder's Name _____ DOB _____

Policy Holders Sex: M F Policy Holder's Employer _____

Name of nearest relative not living with you (in case of emergency) _____

City _____ Telephone _____

Who referred you to our office _____

CURRENT HEALTH

What are your chief symptoms? _____

Secondary Complaints _____

When did your problem begin? _____

How did it begin? (check one) ___ Auto Accident ___ Work Related ___ Other (please describe) _____

Who is your physician _____ City _____ Phone _____

Have you had chiropractic care for this or any other condition? (if yes, please describe) _____

Females are you pregnant? _____ Date of last menstrual period _____

PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST TO BE PHOTOCOPIED. THANK YOU!
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature _____ Date _____
(if patient is a minor, name of parent or guardian)

OVER PLEASE

PERSONAL AND SOCIAL HISTORY

Please list all medications you are taking (including over-the-counter remedies or birth control pills)_____

Please list any fractures or dislocations_____

Have you ever been diagnosed as having or suffering from: (Place check mark by conditions that apply to you)

<input type="checkbox"/> Broken or Fractured Bones	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Drug Addiction
<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Strokes	<input type="checkbox"/> HIV Positive
<input type="checkbox"/> A Congenital Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Gall Bladder
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Ruptures	<input type="checkbox"/> Head Problem
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Depression
	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Tumors

Do you drink alcoholic beverages? _____ Do you smoke? _____ Do you take vitamin supplements? _____

Do you exercise? _____ If yes, frequency and type of exercise _____

Do you have a history of stroke or hypertension? _____

Have you ever had TB (Tuberculosis) (yes) (no)

Have you been living with anyone in the past 2 years who has been diagnosed with TB? (yes) (no)

Have you had a persistent cough & fever for more than 2 weeks? (yes) (no)

Have you had a persistent cough & night sweats for more than 2 weeks? (yes) (no)

Have you had a persistent cough & loss of appetite for more than 2 weeks? (yes) (no)

Have you been coughing or spitting up bloody sputum (saliva)? (yes) (no)

Please list any other health problems you have, no matter how insignificant they may be _____

FAMILY HISTORY

PARENTS:

Father: living ___deceased___ Current age if still living: _____
(check one) Cause of death and age if deceased _____

Mother: living ___deceased___ Current age if still living: _____
(check one) Cause of death and age if deceased _____

OR

(check if applicable to you): _____ As an adopted child, little is known of birth parents or family.

FAMILY DISEASES

(check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

TB _____ Cancer _____ Mental Illness _____ Diabetes _____ Asthma _____
Heart Disease _____ Stroke _____ Kidney Disease _____ Lung Disease _____
Arthritis _____ Liver Disease _____ Other _____

