

# Patient Introduction Card

Date \_\_\_\_\_

Name \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_  
(last) (first) (middle)

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Number of Children \_\_\_\_\_  
(month) (day) (year)

Occupation or Profession \_\_\_\_\_

Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Their Health \_\_\_\_\_

Briefly Describe Complaint \_\_\_\_\_

Referred by \_\_\_\_\_ Have you had chiropractic before? \_\_\_\_\_ Date \_\_\_\_\_

Have you health insurance? \_\_\_\_\_ What company? \_\_\_\_\_

Do you have a major medical reimbursing insurance? \_\_\_\_\_ What company? \_\_\_\_\_

Is your problem due to a recent auto accident or workmen's compensation injury \_\_\_\_\_  
 Failure to notify us may jeopardize your claim.

Social Security Number \_\_\_\_\_

Do you have any difficulty with the following: If YES, mark X

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Muscle spasms in neck            | <input type="checkbox"/> Cold sweats              |
| <input type="checkbox"/> Shooting head pains    | <input type="checkbox"/> Grating in neck                  | <input type="checkbox"/> Liver trouble            |
| <input type="checkbox"/> Sinus trouble          | <input type="checkbox"/> Tightness of shoulder muscles    | <input type="checkbox"/> Gall bladder trouble     |
| <input type="checkbox"/> Loss of smell          | <input type="checkbox"/> Neuritis in shoulders and arms   | <input type="checkbox"/> Indigestion              |
| <input type="checkbox"/> Hayfever               | <input type="checkbox"/> Pins and needles in arms & hands | <input type="checkbox"/> Intestinal gas           |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Cold hands                       | <input type="checkbox"/> Constipation             |
| <input type="checkbox"/> Loss of taste          | <input type="checkbox"/> Chest pains                      | <input type="checkbox"/> Kidney trouble           |
| <input type="checkbox"/> Tightness of throat    | <input type="checkbox"/> Shortness of breath              | <input type="checkbox"/> Bladder trouble          |
| <input type="checkbox"/> Inflammation of throat | <input type="checkbox"/> T.B.                             | <input type="checkbox"/> Menstrual cramps & pain  |
| <input type="checkbox"/> Thyroid trouble        | <input type="checkbox"/> Heart pain                       | <input type="checkbox"/> Menstrual irregularity   |
| <input type="checkbox"/> Face flushed           | <input type="checkbox"/> Heart palpitation                | <input type="checkbox"/> Diabetes                 |
| <input type="checkbox"/> Twitching of face      | <input type="checkbox"/> Heart attacks                    | <input type="checkbox"/> Cancer                   |
| <input type="checkbox"/> Loss of memory         | <input type="checkbox"/> High blood pressure              | <input type="checkbox"/> Sleeping problems        |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Low blood pressure               | <input type="checkbox"/> Painful joints           |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Anemia                           | <input type="checkbox"/> Swollen joints           |
| <input type="checkbox"/> Head feels too heavy   | <input type="checkbox"/> Rheumatic fever                  | <input type="checkbox"/> Arthritis                |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Nervous stomach                  | <input type="checkbox"/> Slipped disc             |
| <input type="checkbox"/> Fainting               | <input type="checkbox"/> Stomach trouble                  | <input type="checkbox"/> Pinched nerves in back   |
| <input type="checkbox"/> Loss of balance        | <input type="checkbox"/> Ulcers                           | <input type="checkbox"/> Pins and needles in legs |
| <input type="checkbox"/> Ringing in ears        | <input type="checkbox"/> Nerves and nervousness           | <input type="checkbox"/> Swollen ankles           |
| <input type="checkbox"/> Wear glasses           | <input type="checkbox"/> Inner tension                    | <input type="checkbox"/> Cold feet                |
| <input type="checkbox"/> Lights bother eyes     | <input type="checkbox"/> Irritability                     | <input type="checkbox"/> Pains in legs & feet     |

ANY FALLS, ACCIDENTS, INJURIES?

Yes  No

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

SURGERY? Yes  No

If yes, please give kind and date \_\_\_\_\_

\_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medication taken, if any \_\_\_\_\_

\_\_\_\_\_