CONFIDENTIAL PATIENT INFORMATION
Edinboro Family Chiropractic
12650 Edinboro Road
Edinboro, PA 16412

Name_____________________________ DOB_____________ Sex: Male, Female, Other
Address_________________________ City____________________
State_________Zip_______
SSN:______-____-_____ Phone: _________________ Email:________________

Do you have an Advanced Health Care Directive (Living will/ DNR)**?** Y / N
Marital Status: Single- Married- Widowed- Divorced-Separated- Partnered
Ethnicity: African American- Caucasian- Hispanic- Not Hispanic- Other_________________
Sexual Orientation: Heterosexual / Homosexual /Bisexual / Chose not to disclose **Student?**: Y/N
Do you have Health Insurance? Y/N Name of insurance:___________________________
Who is financially responsible for this bill?_______________________________________
Do you have AFLAC? Y/N
Will you want a claim form to submit to AFLAC? Y/N ($5.00 fee applies)

Employer______________________ Occupation_____________Employer Phone___________

Emergency Contact____________Relationship______________Phone:__________________

Where did you hear about us?

Phone book/ Internet /Friend/ Family /Health Fair /Billboard/ Poster /Lecture /Other_________
If Friend/ Family, please give name____________________________________
Do we have your permission to send a thank you letter? Y/N

HISTORY OF INJURY

Describe your major complaint______________________________________
Date of Onset__________
Is it work or auto related? Y/N
Have you seen a Physician for the present complaint? YES/NO Who/ When______________
Have you had any X-rays/ MRI/ CT Scan taken? YES/ NO Where and When
Please rate the severity of your problem- Mild- Moderate Severe

PAST MEDICAL HISTORY

Who is your PCP____
What conditions are you currently being treated for___________________________________
Previous Operations_________________________________Serious Illnesses_____________
Hospitalizations____________________________________ When/ Where________________
List any medications and the condition you are being treated for_________________________
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FAMILY HISTORY

Please abbreviate relation- M=Mother, F=Father, S=Sister, B=Brother, Grand(parent)=G, Relation=R

Osteoporosis	Heart Problems	Cancer
High Blood Pressure	Stroke	Unknown
Bleeding Disorders	Genetic Disorders	Other
Diabetes	Heart Attack	

Do you have any sensitivities or drug allergies?____

Date of last Physical Exam?__________ Height________________ Weight___________

REVIEW OF SYSTEMS (Circle any of the symptoms you are **CURRENTLY** experiencing.)

Chest Pain	Tingling	Prolonged Bleeding	Spasms/ Cramps
Dizziness	Rash	Numbness	Poor Balance
Excessive Fatigue	weakness	Headaches	Tremors
Lightheaded	Easy bruising	Visual Disturbances	Sinus Trouble
Fever	Nervousness	Abdominal Pain	Night sweats
Seizure	Insomnia	Weight change	

Have you ever had Chiropractic Care? Y/N Who________________ When____________

Have you ever had Massage Therapy? Y/N

Have you ever had Physical Therapy? Y/N

SOCIAL HISTORY

Are you a current smoker? Y/N How long have you smoked______ Packs/ day ______

Former Smoker? Y/N How long did you smoke?_________

Number of Packs/Day_________ How long since you quit? __________

Do you currently drink alcohol? Y/N If yes, how often? ___________

Do you use illicit drugs? Y/N

Females Only:

Is there any possibility you are pregnant?___________ If so, how many weeks?___________

Date of last menstrual cycle_________________________________

I have disclosed all of my known health history and information truthfully and to the best of my knowledge.

Patient Signature____Date________________