



**American Family Chiropractic Center**

5250-B Courseview Drive Mason, Ohio 45040

**Office:** (513) 398-6300

**Fax:** (513) 398-6363

Thank you for downloading the Patient History Form.

Now that you have the Form, you can fill it out at your leisure and find, check all the information required before coming to the office.

We recommend the Patient History Form be faxed to our office prior to your visit.

This is our Fax number: **(513) 398-6363**

By sending us your information, the amount of time spent filling out, signing and checking forms is greatly reduced.

We are looking forward to seeing you soon.  
The Staff of American Family Chiropractic Center

**PATIENT INFORMATION**

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Date: \_\_\_\_\_

S. S. ID#: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
Last Name

\_\_\_\_\_ Middle Initial

\_\_\_\_\_ First Name

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_

Sex: M F Age: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Married ( ) Widowed ( ) Single ( ) Minor ( )  
 Separated ( ) Divorced ( )  
 Partnered for \_\_\_\_\_ years

Occupation: \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address: \_\_\_\_\_

Employer/School Phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Whom may we thank for referring you?  
 \_\_\_\_\_

**PHONE NUMBERS**

Home Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

Best time and place to reach you:  
 \_\_\_\_\_

**IN CASE OF EMERGENCY CONTACT**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

**INSURANCE**

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Group #: \_\_\_\_\_

Is patient covered by additional Insurance? YES NO

Subscriber's Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Group #: \_\_\_\_\_

**Assignment and Release**

I certify that I, and/or my dependant (s), have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is complete or one year from the date signed below.

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
 Print Name of Patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to Patient:

**ACCIDENT INFORMATION**

Is condition due to an accident? YES NO

Date: \_\_\_\_\_

Type of accident: ( ) Auto ( ) Work ( ) Home  
 Other \_\_\_\_\_

To whom have you made a report of your accident?  
 ( ) Auto Insurance ( ) Employer ( ) Worker Comp  
 ( ) Other

Attorney name (if applicable)  
 \_\_\_\_\_

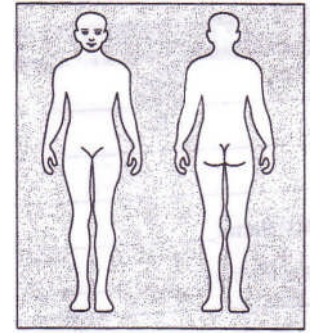
## PATIENT CONDITION

Reason for visit: \_\_\_\_\_

When did symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse? ( ) YES ( ) NO

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

Type of pain: ( ) Sharp ( ) Dull ( ) Throbbing ( ) Numbness ( ) Aching  
 ( ) Shooting ( ) Burning ( ) Tingling ( ) Cramps ( ) Stiffness ( ) Swelling  
 ( ) Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your ( ) work ( ) Sleep ( ) Daily Routine ( ) Recreation

Activities or movements that are painful to perform ( ) Sitting ( ) Standing ( ) Walking ( ) Bending  
 ( ) Lying down

## HEALTH HISTORY (Part 1)

What treatment have you already received for your Condition?

( ) Medications ( ) Surgery ( ) Physical Therapy ( ) Chiropractic Care ( ) None  
 ( ) Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition:

Date of Last Physical Exam \_\_\_\_\_ Spinal X-ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-ray \_\_\_\_\_ Urine Test \_\_\_\_\_ Dental X-ray \_\_\_\_\_

MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "NO" to indicate if you have any of the following:

AIDS/HIV	YES NO	Diabetes	YES NO	Migraine Headaches	YES NO	Scarlet fever	YES NO
Alcoholism	YES NO	Emphysema	YES NO	Miscarriage	YES NO	Stroke	YES NO
Allergy Shots	YES NO	Epilepsy	YES NO	Mononucleosis	YES NO	Suicide Attempt	YES NO
Anemia	YES NO	Fractures	YES NO	Multiple Sclerosis	YES NO	Thyroid Problems	YES NO
Anorexia	YES NO	Glaucoma	YES NO	Mumps	YES NO	Tonsillitis	YES NO
Appendicitis	YES NO	Goiter	YES NO	Osteoporosis	YES NO	Tuberculosis	YES NO
Arthritis	YES NO	Gonorrhea	YES NO	Pace Maker	YES NO	Tumors, Growths	YES NO
Asthma	YES NO	Heart Disease	YES NO	Parkinson's Disease	YES NO	Typhoid Fever	YES NO
Bleeding Disorders	YES NO	Hepatitis	YES NO	Pinched Nerve	YES NO	Ulcers	YES NO
Breast Lump	YES NO	Hernia	YES NO	Pneumonia	YES NO	Vaginal Infections	YES NO
Bronchitis	YES NO	Herniated Disc	YES NO	Polio	YES NO	Venereal Disease	YES NO
Bulimia	YES NO	Herpes	YES NO	Prostrate Problem	YES NO	Whooping Cough	YES NO
Cancer	YES NO	High Cholesterol	YES NO	Prosthesis	YES NO	Other	
Cataracts	YES NO	Kidney Disease	YES NO	Psychiatric Care	YES NO		
Chemical Dependency	YES NO	Liver Disease	YES NO	Rheumatoid Arthritis	YES NO		
Chicken Pox	YES NO	Measles	YES NO	Rheumatic Fever	YES NO		

### HEALTH HISTORY (Part 2)

EXERCISE	WORK ACTIVITY	HABITS
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking Packs/Day _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol Drinks/Week _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine Drinks Cups/Day ____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy labor	<input type="checkbox"/> High Stress Level Why _____

Are you Pregnant? YES NO Due Date: \_\_\_\_\_

Injuries/Surgeries you have had:	Description	Date
FALLS		
HEAD INJURIES		
BROKEN BONES		
DISLOCATIONS		
SURGERIES		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

Pharmacy Name: \_\_\_\_\_

Pharmacy Phone: (\_\_\_\_) \_\_\_\_\_