Mill Creek Chiropractic Clinic

Confidential Patient Information

Name _____ MI _____ Birth Date _____ Age _____

Address _____ City_____Zip_____

Gender _____ Marital Status: M S D W Live with: _____

Race: American Indian or Alaska Native/ Asian / Black or African American / Native Hawaiian or Pacific Islander
White (Caucasian) / Other / Decline to Answer

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Preferred Language: English or _____ Personal Email Address _____

Home Phone Number _____ Work Phone Number_____ May we contact you at work? Y N

Cell Number _____Cell Carrier (if you would like texts)_____

Preferred method of communication for patient reminders: Email / Phone / Mail / Text

Patient Employer _____ Occupation _____

Address of Employer_____

Your SSN _____ Person financially responsible for your account? Self or _____

Policy holders name_____ Birth Date (if someone else): _____

Relationship to policy holder: Self Spouse Child

Insurance company _____ ID #_____

ER Contact Person _____Phone:_____ Relationship: _____

Purpose of this appointment: _____ Date of onset: _____

Other doctors seen for this condition:_____

Is this the result of an auto accident? Yes No Accident date: _____ Job related? Yes No

If disabled, give dates:_____

Primary Care Physician Name _____ Phone #_____

Medications: _____

_____

Medical Allergies and Reactions: _____

_____

Major Surgeries and Year: _____

Hospitalizations- Date and Reason: _____

Major Illness and Year: _____

Treatment for ANY Condition in the Last Year: _____

Previous Chiropractic Care (Who and When): _____

Family Illness History - Who and What (Anything Major:)_____

_____

Smoking Status (4000F CPT) : Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Alcohol (#) _____ per: _____ Caffeine: _____ per: _____ Drug Use: _____

Exercise: _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment, however, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

Musculo-Skeletal Code

Low back pain
Pain between the shoulders
Neck pain
Arm pain
Joint pain/stiffness
Walking problems
Difficult chewing/clicking jaw

Nervous System Code

Numbness
Paralysis
Dizziness
Forgetfulness
Confusion/Depression
Fainting
Convulsions
Cold/Tingling Extremities

General Code

Loss of sleep
Fever
Headaches

Genito-Urinary Code

Bladder Trouble OR discolored urine
Painful/Excessive urination

Gastro Intestinal Code

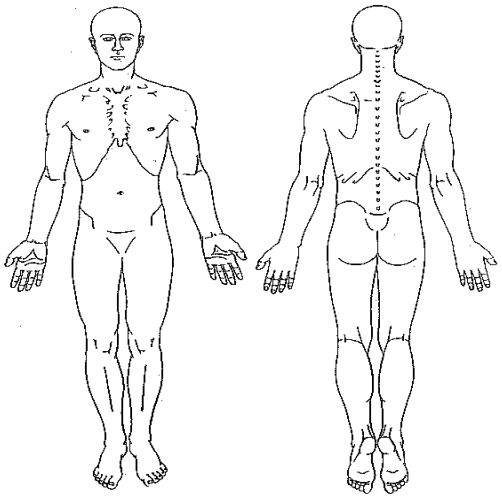
Poor/excessive appetite
Excessive thirst
Frequent nausea
Vomiting
Diarrhea
Constipation
Hemorrhoids
Liver Trouble
Gall Bladder Problems
Weight Trouble
Abdominal Cramps
Gas/Bloating After Meals
Heartburn
Black/Bloody Stool
Colitis

C-V-R Code

Chest pain
Short Breath
Blood Pressure Problems
Irregular Heartbeat
Heart Problems
Lung Problems/Congestion
Varicose Veins
Ankle Swelling
High Blood Pressure: Yes No 401.09

EENT Code
Vision Problems
Dental Problems / Sore Throat
Ear Aches
Hearing Difficulty
Stuffed Nose

Please mark areas of pain on body diagram below



Male/Female Code

Menstrual Irregularity
Menstrual Cramping
Vaginal Pain/Infections
Breast Pain or Lumps
Prostate/sexual Dysfunction

Are you pregnant?

Yes No Maybe

When was your last menstrual period?_____

Diabetes?	**Type I**	**Type II**
Yes No	**250.01**	**250.00**

I authorize to have Mill Creek Chiropractic contact me via phone, email and/or text for secure or non-secure purposes initial: _____

Please note for all patients, the first visit fees are due on the first day. If your insurance is verified prior to your visit, using our confirmation form, we will accept direct payment from your insurance company for their portion. You may call your insurance company from our office to verify coverage, if you desire.

Signature:_____ Today's Date:_____

Print Name: _____