



**SUMMIT  
CHIROPRACTIC  
& REHABILITATION**

***Chiropractic, Sports and Neurology Rehabilitation  
Orthotic Fitting and Gait Analysis***

**PATIENT INFORMATION**

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print) \_\_\_\_\_ Date \_\_\_\_\_  
Name \_\_\_\_\_ S.S. \_\_\_\_\_  
First M.I. Last  
Physical Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Birth Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_  
E-Mail \_\_\_\_\_  
Your Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Spouse's/Parent's Name \_\_\_\_\_ Workplace \_\_\_\_\_  
Spouse's/Parent's Work Phone \_\_\_\_\_  
Who referred you to our practice? \_\_\_\_\_  
Family Doctor or Referring Doctor \_\_\_\_\_  
Person to contact in case of emergency, living outside of home. \_\_\_\_\_ Phone \_\_\_\_\_

**RESPONSIBLE PARTY**

Name of person responsible for this account (other than yourself) \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Phone # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Name and address of Employer \_\_\_\_\_  
Work Phone# \_\_\_\_\_

**INSURANCE INFORMATION**

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_ Date employed \_\_\_\_\_  
Name of employer \_\_\_\_\_ Work phone # \_\_\_\_\_  
Address \_\_\_\_\_ ZIP \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Phone#( ) \_\_\_\_\_ Group# \_\_\_\_\_  
Insurance Address \_\_\_\_\_ Adjuster Name & Phone \_\_\_\_\_  
Date of accident \_\_\_\_\_ Claim # \_\_\_\_\_

Thank you and we appreciate your help.

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

## SYMPTOMS

Reason for visit? \_\_\_\_\_

When did you first notice symptoms and/or date of accident? \_\_\_\_\_

Is this condition getting progressively worse? \_\_\_\_\_

Please list all x-rays/MRI's/CATscans taken in the past two years \_\_\_\_\_

Please list all surgeries/broken bones/injuries (include dates) \_\_\_\_\_

Date of last : physical exam \_\_\_\_\_ chiropractic exam \_\_\_\_\_ gynecological exam \_\_\_\_\_

Name/address of your family physician \_\_\_\_\_

Name/address of your previous chiropractor \_\_\_\_\_

Please list all medications you are now taking \_\_\_\_\_

Please list all supplements or vitamins you are now taking \_\_\_\_\_

(Women) Are you pregnant? \_\_\_ Yes \_\_\_ No Nursing? \_\_\_ Yes \_\_\_ No Taking birth control pills \_\_\_ Yes \_\_\_ No

Please list any allergies you may have \_\_\_\_\_

Have you or do you have?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> high cholesterol |
| <input type="checkbox"/> anemia              | <input type="checkbox"/> stroke          | <input type="checkbox"/> polio            |
| <input type="checkbox"/> tuberculosis        | <input type="checkbox"/> pneumonia       | <input type="checkbox"/> measles          |
| <input type="checkbox"/> mumps               | <input type="checkbox"/> chicken pox     | <input type="checkbox"/> shingles         |
| <input type="checkbox"/> diabetes            | <input type="checkbox"/> cancer          | <input type="checkbox"/> diabetes         |
| <input type="checkbox"/> epilepsy            | <input type="checkbox"/> alcoholism      | <input type="checkbox"/> HIV              |

## HEALTH HISTORY (check only those conditions which are applicable):

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> chronic constipation | <input type="checkbox"/> frequent urination  | <input type="checkbox"/> asthma                |
| <input type="checkbox"/> chronic diarrhea     | <input type="checkbox"/> painful urination   | <input type="checkbox"/> hay fever             |
| <input type="checkbox"/> rectal bleeding      | <input type="checkbox"/> blood in urine      | <input type="checkbox"/> frequent colds        |
| <input type="checkbox"/> kidney infection     | <input type="checkbox"/> kidney stones       | <input type="checkbox"/> chest pains           |
| <input type="checkbox"/> eye pains            | <input type="checkbox"/> headaches           | <input type="checkbox"/> earaches              |
| <input type="checkbox"/> ringing in ears      | <input type="checkbox"/> frequent nosebleeds | <input type="checkbox"/> difficulty swallowing |

### FOR WOMEN ONLY

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> irregular cycles | <input type="checkbox"/> painful menstruation | <input type="checkbox"/> excessive flow |
| <input type="checkbox"/> hot flashes      | <input type="checkbox"/> vaginal discharge    |   |

Please list the ages, health problems (past and present) or cause of death of:

Mother \_\_\_\_\_

Father \_\_\_\_\_

Siblings \_\_\_\_\_

Children \_\_\_\_\_

Other primary relatives: \_\_\_\_\_

Are you wearing :  orthotics  heel lifts  sole lifts  insoles

How old is your mattress: \_\_\_\_\_ It is  comfortable  uncomfortable  waterbed  conventional

How many hours of sleep per night? \_\_\_\_\_ How many pillow? \_\_\_\_\_

You usually sleep on your  back  side R L  stomach with head turned to R L

Are you a cigarette  smoker  nonsmoker  ex-smoker Other: Cigar \_\_\_\_\_ Pipe \_\_\_\_\_

How many years have/had you been smoking? \_\_\_\_\_

Cigarettes/cigar per day \_\_\_\_\_

How much liquor do you consume on a weekly basis? \_\_\_\_\_

How much coffee or caffeinated beverages do you consume on a daily basis? \_\_\_\_\_