**MINORIK CHIROPRACTIC CENTER**
2620 W Market Street
Fairlawn, OH 44313
(330) 869-6566

Patient ID #____________________

Date ____________________

CONFIDENTIAL PATIENT INFORMATION

Social Security # ____________________

**Name** ____________________ **Home Phone** ____________________ **Cell Phone** ____________________

**Address** ____________________ **City** ____________________ **State** _______ **Zip** _________

Age _______ **Birth Date** _______________ **Marital Status**: ☐ Married ☐ Single ☐ Widowed ☐ Divorced # of Children _________

☐ **Male** ☐ **Female** **Height** _______ **Weight** ________ Email ____________________

**Race/Ethnicity**: ☐ Caucasian ☐ African American ☐ Asian American ☐ Hispanic/Latino ☐ Other ____________________

Occupation ____________________ Employer ____________________

Address ____________________ Office Phone ____________________

Name of Wife/Husband ____________________ Occupation ____________________

Employer ____________________ Office Phone ____________________

Patient's Nearest Relative ____________________ Address ____________________

Home Phone ____________________ Work Phone ____________________

Referred by ____________________ **Tobacco Use** ☐ Yes ☐ No Frequency ____________________

Who should we contact in case of emergency? ____________________ Phone ____________________

Date of Last Physical Examination ____________________ Family Physician ____________________

**Medications** ____________________ ☐ None

**Allergies** ____________________ ☐ None

Check any of the following symptoms you have experienced in the last six months:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Dizziness | ☐ | Asthma | ☐ | Low Back Pain | ☐ | Pain in Legs | ☐ |
| Backaches | ☐ | Neuritis | ☐ | Pain Between Shoulder Blades | ☐ | Pain in Feet | ☐ |
| Heart Trouble | ☐ | Digestive Issues | ☐ | Tension across top of shoulders | ☐ | Difficulty sleeping | ☐ |
| Diabetes | ☐ | Nervousness | ☐ | Fibromyalgia | ☐ | Allergies | ☐ |
| Tuberculosis | ☐ | Sinus Trouble | ☐ | Numbness/Tingling in Arms/Hands | ☐ | Carpal Tunnel | ☐ |
| Arthritis | ☐ | Anemia | ☐ | Numbness Tingling in Legs/Feet | ☐ | Neck Pain | ☐ |
| Headaches | ☐ | Cancer | ☐ | Tired/Fatigue | ☐ | Tension | ☐ |

Which of the above is the worst? ____________________ How long have you had it? ____________________

How often does it occur? ____________________ What does it feel like? ____________________

What has helped this problem? ____________________ What activities has this effected? ____________________

| *Does this cause you to be:* | *Does this effect your work:* | *Does this effect your life:* |
|---|---|---|
| ☐ Moody | ☐ Decision Making | ☐ Lose Patience with Spouse/Children |
| ☐ Irritable | ☐ Poor Attitude | ☐ Restricted Household Duties |
| ☐ Interrupt Sleep | ☐ Decreased Productivity | ☐ Hinders Ability to Exercise |
| ☐ Restrict Your Daily Activities | ☐ Exhausted at End of Day | ☐ Interferes with Hobbies/Other |
| | ☐ Unable to Work Long Hours | |

Reason for Today's Appointment ____________________ Other Doctors seen for this Condition? ____________________

Have you been treated for any health condition by a Physician in the last year? ☐ Yes ☐ No Describe ____________________

What have you tried to help relieve this problem and how much did it help?

| | | | |
|---|---|---|---|
| ☐ Medications | *Helped: Little Some Much* | ☐ Exercise | *Helped: Little Some Much* |
| ☐ Physical Therapy | *Helped: Little Some Much* | ☐ Nutrition | *Helped: Little Some Much* |
| ☐ Chiropractic | *Helped: Little Some Much* | ☐ Stretching | *Helped: Little Some Much* |

PAYMENT IS EXPECTED AT THE TIME OF VISIT. Will you be paying today by: ☐ Cash ☐ Check ☐ Credit Card

Are You Insured? ☐ Yes ☐ No Company ____________________ Policy # ____________________

Name of Person Responsible for Payment/Policy Holder____________________Birthdate of Policy Holder _______________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that MINORIK CHIROPRACTIC CENTER will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to MINORIK CHIROPRACTIC CENTER will be credited to my account on receipt. However, I clearly understand and agree that any services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature ____________________ Date ____________________

Guardian or Spouse's Signature ____________________Date _____________ Information Taken By ________

**IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE FOLLOWING QUESTIONS**

Date of the Accident ______________________ Time _________________ AM / PM Location ___________________________________

How did Accident Occur? ☐ Auto Collision ☐ On the job Injury ☐ Other _________________________________________________

If On-the-job Injury, how did it happen? ___________________________________________________________________________

_____________________________________________________________________________________________________________

_____________________________________________________________________________________________________________

Did you report the injury to you foreman or employer? ☐ Yes ☐ No Your Job Title/Duties? ______________________

Did you tell them you were coming to our office? ☐ Yes ☐ No ________________________________________

If auto accident, were you: ☐ Driver ☐ Passenger ☐ Pedestrian ________________________________________

If auto collision, were you struck from: ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Parked ☐ Other _________________________

Did your car strike the other(s) involved? ☐ Yes ☐ No ☐ Undetermined

OR did the other car strike yours? ☐ Yes ☐ No ☐ Undetermined

As a result of the accident, were traffic citations issued to you? ☐ Yes ☐ No

Or to the driver of the other car? ☐ Yes ☐ No

Or to the driver of your car? ☐ Yes ☐ No ☐ Not Applicable

List the extent of the injuries as you know them ___________________________________________________________________

_____________________________________________________________________________________________________________

_____________________________________________________________________________________________________________

Did you require post-accident hospitalization? ☐ Yes ☐ No

Check Symptoms you have noticed since the accident:

☐ Headache
☐ Neck Pain
☐ Neck Stiffness
☐ Problems Sleeping
☐ Back Pain
☐ Nervousness
☐ Tension
☐ Irritability
☐ Chest Pain

☐ Dizziness
☐ Head Seems Too Heavy
☐ Pins & Needles in Arms
☐ Pins & Needles in Legs
☐ Numbness in Fingers
☐ Numbness in Toes
☐ Shortness of Breath
☐ Fatigue
☐ Depression

☐ Light Bothers Eyes
☐ Loss of Memory
☐ Ears Ring
☐ Face Flushed
☐ Buzzing in Ears
☐ Loss of Balance
☐ Fainting
☐ Loss of Smell
☐ Loss of Taste

☐ Diarrhea
☐ Feet Cold
☐ Hands Cold
☐ Stomach Upset
☐ Constipation
☐ Cold Sweats
☐ Fever
☐ ____________________
☐ ____________________

Symptoms other than above _____________________________________________________________________________________

_____________________________________________________________________________________________________________

Have you lost any days of work? ☐ Yes ☐ No Dates: ____________________________________________________________

Insurance Companies Involved (Auto Accidents Only)

My Company ___________________________________________________________________________________________

Company of person responsible for injuries ______________________________________________________________

Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ Yes ☐ No

Do you have an attorney that has advised you in this case? ☐ Yes ☐ No

Attorney's Name ________________________________________________________________________________________

Address _________________________________________________________ Phone ___________________________