

**BOGGS CHIROPRACTIC**

3939 Massillon Rd. #201

Uniontown, OH 44685

(330) 896-2424

[www.boggschiropractic.com](http://www.boggschiropractic.com)

File Number: \_\_\_\_\_

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

**CONFIDENTIAL PATIENT INFORMATION**

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Marital Status:  Married  Single  Widowed  Divorced Number of Children: \_\_\_\_\_

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

Work Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Personal Email: \_\_\_\_\_ Work Email: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Work Phone: \_\_\_\_\_

Spouse's Personal Email: \_\_\_\_\_ Spouse's Health Status: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

**CURRENT COMPLAINTS**

Major health concern(s): \_\_\_\_\_

Is your visit related to:  Automobile Accident  Work Injury  Other: \_\_\_\_\_

Please describe injury: \_\_\_\_\_

Date of injury: \_\_\_\_\_ Date symptoms appeared: \_\_\_\_\_

Have you received treatment for current symptoms?  No  Yes If yes, explain: \_\_\_\_\_

Have you been under chiropractic care before?  No  Yes If yes, when was your last treatment? \_\_\_\_\_

**PAYMENT INFORMATION**

Payment is expected at the time of service. Will you be paying:  Cash  Credit  Check

Name of person responsible for payment: \_\_\_\_\_ Are you insured?  No  Yes

Insurance Company Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_ Claim #: \_\_\_\_\_

**I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that BOGGS CHIROPRACTIC 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 BOGGS CHIROPRACTIC will be credited to my account on receipt. However, I clearly understand and agree that any services rendered to 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 to me will be immediately due and payable.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or Spouse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_ File Number: \_\_\_\_\_

**MEDICAL HISTORY**

Have you been treated for any conditions in the last year?  Yes  No If yes, please describe below:

Date of last physical exam? \_\_\_\_\_ Is there any chance that you are currently pregnant?  Yes  No

Have you had X-rays taken in the last 6 months?  Yes  No If yes, where? \_\_\_\_\_

Are you currently diagnosed with any illnesses or other health conditions?

Health Condition	Date diagnosed	What is your doctors name?	Address

Please list any medications that you are currently taking:

Medication/Supplement	Dose	Frequency	Purpose for taking	Has this been beneficial?

Please list any fractures or surgeries you have had:

Location of break/fracture	Date incurred	Location of surgery	Date incurred	Was this succesful?

Please list any family history of illness (heart disease, stroke, cancer, diabetes, arthritis, etc.):

Family Member	Present and/or past health conditions

Habits:

	<u>None</u>	<u>Light</u>	<u>Moderate</u>	<u>Heavy</u>
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____
Soft Drinks	_____	_____	_____	_____
Water	_____	_____	_____	_____
Salty Foods	_____	_____	_____	_____
Sugary Foods	_____	_____	_____	_____
Artificial Sweeteners	_____	_____	_____	_____

Please list any repetitive movements, positions, or activities you do on a daily basis: \_\_\_\_\_

Please check any of the following that you have experienced in the past six months.

	Past	Present
Allergies		
Anxiety		
Asthma		
Blood in Stool		
Blood in Urine		
Blurred Vision		
Bruise Easily		
Chest Pain		
Cold Extremities		
Constipation		
Cramps		
Depression		
Diarrhea		
Dizziness		
Ringing in Ears		
Excessive Menstruation		
Excess Persperation		
Eye Pain		
Fatigue		
Frequent Urination		
Headache		
Heartburn		
Hemorrhoids		
High Blood Pressure		
Hot Flashes		
Indigestion/Gas		
Irregular Heart Beat		
Irregular Breathing		
Irregular Cycle		
Light Headed/Fainting		
Loss of Balance		
Loss of Hearing		
Loss of Smell		
Loss of Taste		
Memory Loss		
Nose Bleeds		
Prostrate Trouble		
Reproductive Issues		
Shortness of Breath		
Sinus Trouble		
Skin Irritation		
Sleep Issues		
Swallowing Difficulty		
Swelling in Joints		
Ulcers		
Urinary Problems		
Varicose Veins		
Other:		
Other:		
Other:		
Other:		
Other:		
Other:		

Please shade the drawing below to indicate the location of your symptoms. Use the letters to indicate the type of symptoms you are currently experiencing in that shaded region.

- A=Ache
- B=Burn
- N=Numbness
- P=Pins & Needles
- S=Sharp
- T=Tight/Tense
- O=Other (Please describe)

