MURRAY HILL CHIROPRACTIC P.C.

CONFIDENTIAL PATIENT INFORMATION

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately and completely. Thank You.

Date________________ Home/Cell________________________ Email ____

Name ____SSN______________________________

Street ____ City, State _____________________________Zip___________

Age______ DOB________________ Marital Status S M W D How Many Children_______

Occupation ____ Employer_______________________________

Address____ Office______________________

Phone_____________________________

NameofWife/Husband______________________________________ Occupation_______________________________

Employer____Office_____________Phone_________________

Other____________________Nearest-Relative_______________________________________

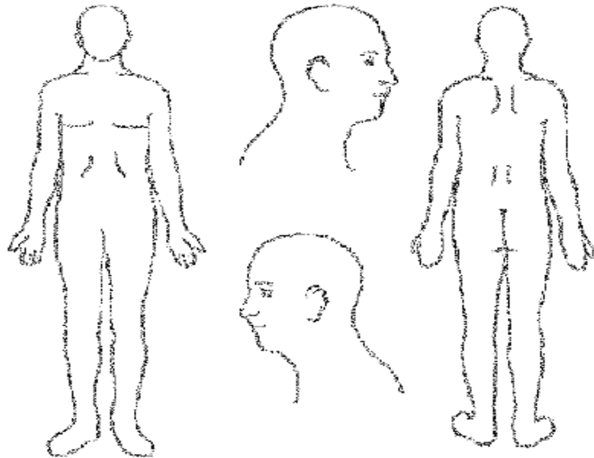
Phone___________________________________

Heard about our office through____

Have you ever been to a Chiropractor before Y/N

Have you ever been treat at one of our clinics Y/N

Please mark your areas of pain on the figures below



List present complaints, injuries and duration:

1. ____
   ____
2. ____
   ____
3. ____
   ____

Remarks and details of any accident: ____________________

____

____

____

____

List other doctors consulted for present complaints and injuries:

Name _______________________________ What kind of Dr._______________________ When consulted____________

Diagnosis____ Treatment/X-rays___________

How long did you see the Doctor?____ How frequently?___________

Results____

Name _______________________________ What kind of Dr._______________________ When consulted____________

Diagnosis____ Treatment/X-rays___________

How long did you see the Doctor?____ How frequently?___________

Results____

Present family doctor ____

Date of last physical examination____ By Doctor_______________

What surgeries have you had

Type/When/Doctor/Remarks____
____
____

List former serious accidents and falls: (auto, work, home, leisure, sports, other – circle one)
What/When/Symptoms/Treatment/Results____
____
____

List broken Bones:
What/When/Remarks____
____
____

List medications and/or diet supplements you take:
What/Frequency/Doctors/Side Effects/Remarks____
____
____

Environment
Work – (Please circle appropriate answer)
Seated/Standing – Work Bench/Desk/Counter/Other____
Job involve – Lifting/Bending/Stooping/Twisting/Turning/Carrying/Walking/Standing/Other______________________
Chair – Executive/Steno/Bench/Stool/Folding/Other_________________ Shoes – High hells/Boots/Other___________

In order to help our patients obtain all insurance benefits for which they are eligible, we will need the following information completed.

GROUP HEALTH (Please complete in addition to Auto and Workmen's Comp. info)
PrimaryCo. ____
Address____
Deductible $_______ Already Paid □ No □ Not Known.
Percentage Insurance Co. pays (if known) ________________%
Insured_____________________________________Relationship-to-Insured__________________________
S.S#____________________________Policy#____________________________Group#________________
SecondaryCo.____
Address____
Deductible $_______ Already Paid □ No □ Not Known.
Percentage Insurance Co. pays (if known) ________________%
Insured______________________________________Relationship-to-Insured_________________________
S.S#____________________________Policy#____________________________Group# ________________