Weisbrod Chiropractic
2133 E. Warner Road, Suite 102
Tempe, AZ 85284

PATIENT INFORMATION

General Information

First Name: ____________________ MI: _____ Last Name: ____________________ Called Name: _______________

Address: ____ City: ________________ State: _____ Zip: ___________

Home Phone: (____) ____-________ Work Phone: (____) ____-________ Cell Phone: (____) ____-________.

E-mail Address: _________________________ Sex: M F Marital Status: Single Married Divorced Other

Birth Date: _____/_____/_____ Social Security #: _____-____-_______ Referred By: __________________________

Work Status: Employed Full-time Student Part-time Student Other Height: ______ Weight: ______

Insured's Information

Patient is: Same Child Husband Wife of Insured. First Name: __________ MI ___ Last Name: ____________

Address: __________________________________ City: ______________ State: ___________ Zip: ______________

Phone Number: (____) ____-________ Social Security #: ____-____-______ Date of Birth: ____/____/____ Sex: M F

Employer Information

Occupation: __________________________________ Employer: ____

Address: __________________________________ City: ______________ State: ___________ Zip: ______________

Contact: ____________________________ Phone: (____) ____-__________ Group Number: ___________________

History Information

Is condition related to Employment? Yes No Auto Accident? Yes No Date condition started: ____/____/____

Have you ever had same or similar condition? Yes No If yes please describe: ________________________________

____

List other Doctors seen for this condition: ____

Dates of treatment: ____

Carrier Information (office to obtain a copy of card)

Name of Company: ______________________________________ Plan: ____________________________________

Guarantor (If other than patient)

First Name: ________________ MI _____ Last Name: __________________ Relationship: ______________________

Address: __________________________________ City: ______________ State: ___________ Zip: ______________

Home Phone: (____) ____-________ Work Phone: (____) ____-__________ Social Security #: ______-_____-________

I hereby authorize payment directly to Weisbrod Chiropractic of all benefits payable to me but not to exceed the balance due from my treatments. I also authorize Weisbrod Chiropractic to endorse my name on any draft from my auto, medical or health insurance carrier(s) necessary to pay my medical bills. I understand that I am financially responsible for any amounts not covered by my insurance and or all collection costs, including co-pays, reasonable attorney fees incurred in connection with collection of any amounts payable to said doctor. I also authorize Weisbrod Chiropractic to release any information required in the course of my examination or treatment to my insurance carrier.

Patient's Signature: ______________________________________ Date: ____________________________

Insured's Signature: ______________________________________ Date: ____________________________

Weisbrod Chiropractic
2133 E. Warner Road, Suite 102
Tempe, AZ 85284

PATIENT HISTORY

Patient: ____ Date: ________________________

Past History:
Date of Last Physical Exam: _____________________ Doctor Seen: _______________________________

General State Of Health: (Please Circle) Excellent Very Good Good Fair Poor

Please List All Surgeries and Hospitalizations:
1) ____ Date: _______________________

2) ____ Date: _______________________

Previous Fractures and Dates: ____

Previous Injuries: (Car Accidents, Work Injuries, Sports Injuries) _______________________________________

____ Dates: ______________________

Have You Ever Been Under Chiropractic Care? Yes No Doctors Name: ____________________________

Serious Illnesses: ____

Medications:
Are You Taking Any Medication/Vitamins? Yes No (If Yes Please List)
Medication: ______________Purpose: _____________ Medication: ______________ Purpose: _____________
Medication: ______________Purpose: _____________ Medication: ______________ Purpose: _____________
Allergies: ____

Family History: (1.Father 2.Mother 3.Brother 4. Sister) Explain
Cancer ( ) ______________ Diabetes ( ) ______________Cardiac ( ) _____________
Stroke ( ) ______________ HBP ( ) ______________ Other ( ) _____________

Social Habits: (Please Circle Appropriate Responses and/or Fill In The Blanks)
Tobacco: None ___ Pack/Day, Week for ___ Years. **Caffeine:** None (Coffee, Tea, Soda) ___ Cups/Day
Alcohol: None ___ Glasses of Wine, Beer, Mixed Drinks /Day. **Sleep Interrupted?** ___ X's /Night for ___ wks

Exercise: Type: ________________________________ Frequency: _____X's/Week Duration: _____Minutes

Current Condition:
Briefly Describe Your Current Condition: ____

____

Have Your Activities Of Daily Living Been Changed Or Limited Because Of This Condition? Yes No

Please Describe: ____

FEMALE: Are You Pregnant? Yes No Date of Last Menstrual Period: _______________________

Please Write In A Number: 1. Presently Have 2. Previously Had 3. Related To Current Condition

___ Allergy	___ Sleep Difficulty	___ Neck Pain	___ Kidney Stones	___ Constipation
___ Fatigue	___ Seizures	___ Bursitis	___ Prostate Trouble	___ Hemorrhoids
___ Cancer	___ Weight Loss	___ Low Back Pain	___ Lumps In Breast	___ Digestion Disorders
___ Fainting	___ Vision Problems	___ Sciatica	___ Irregular Cycle	___ Painful Menstruation
___ Thyroid Disorder	___ Sinus Infection	___ Stiffness	___ Heart Disease	___ Gall Bladder Trouble
___ Headache	___ Nose Bleeds	___ Foot Trouble	___ Stroke	___ Heartburn
___ Dizziness	___ Asthma	___ Irregular Cycle	___ Varicose Veins	___ Nausea
___ Tremors	___ Hoarseness	___ Blood In Urine	___ Chest Pain	___ Diarrhea
___ Alcoholism	___ Ear Disorder	___ Kidney Infection	___ Chronic Cough	___ High Blood Pressure
___ Numbness	___ Arthritis	___ Frequent Urination	___ Tuberculosis	___ Low Blood Pressure
___ Nervousness	___ Knee Problems	___ Painful Urination	___ Difficulty Breathing	___ Chills
___ Depression	___ Hernia	___ Bedwetting	___ Liver Trouble	___ Sweats