Name: _____ _____

TOY CHIROPRACTIC CLINIC
PATIENT DATA FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Sex: ❑ M ❑ F	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	Name you like to be called:	Birth Date:	Age:	Preferred Language:

Race (circle one) American Indian Asian Black/African American Native Hawaiian Other Pacific Islander White Decline to State	Ethnicity (circle one) Hispanic or Latino Not Hispanic or Latino Decline to state

Address:	City:	State:	ZIP Code:

Social Security No:	Email:	Home no.: ( )	Cell no.: ( )

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Website

❑ Family_____ ❑ Friend_____ ❑ Close to home/work ❑ Yellow Pages ❑ Other_____

Other family members seen here:

PAYMENT INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer phone no.: ( )

Is patient covered by Insurance? ❑ Yes ❑ No | May we contact you at place of employment? ❑ Yes ❑ No

Primary Insurance Provider:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	ID no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	ID no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Contact phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Toy Chiropractic Clinic or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

Name _____

PATIENT INTAKE FORM

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

PERSONAL HEALTH HISTORY

Are your present problems due to an injury? ☐ Yes ☐ No **Date of injury:**

Was the Injury? ☐ Job Related ☐ Auto Accident ☐ Personal Injury ☐ Other _____ ☐ NA

Has the accident been reported? ☐ Yes ☐ No ☐ NA **If so, to whom?** ☐ Employer ☐ Auto Carrier ☐ Other _____

Have you received any Imaging Services due to this condition? ☐ Yes ☐ No **If so, where:** _____

List symptoms you are experiencing today

Do you have any current work restrictions due to this condition?
Off Work: ☐ Yes ☐ No Dates: _____
Light Duty: ☐ Yes ☐ No If so, what were restrictions? _____

Surgeries

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers (if you have a list we can make a copy)

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

Name: _____

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.				
Exercise	☐ Sedentary (No exercise)		☐ Occasional vigorous exercise (i.e. less than 4x/week for 30 min.)	
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		☐ Regular vigorous exercise (i.e. 4x/week for 30 minutes)	
Diet	Are you dieting?			☐ Yes ☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?			☐ Yes ☐ No
	How many drinks per week?			
Tobacco	Do you use tobacco?			☐ Yes ☐ No
	Smoking use: ☐ NA ☐ Former smoker ☐ Light Smoker ☐ Heavy Smoker		Are you attempting to quit? ☐ Yes ☐ No	
Drugs	Do you currently use recreational or street drugs?			☐ Yes ☐ No
Personal Safety	Do you live alone?			☐ Yes ☐ No
	Do you have frequent falls?			☐ Yes ☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		
Father				
Mother				
Sibling	☐ M ☐ F		☐ M ☐ F	
	☐ M ☐ F		☐ M ☐ F	
Grandparent	☐ M ☐ F		☐ M ☐ F	
	☐ M ☐ F		☐ M ☐ F	

OTHER CONDITIONS & SYMPTOMS

General Symptoms	Cardio-Vascular	Muscles & Joints	Gastro-Intestinal	Ear/Eye/Nose/ Throat	Genito-Urinary	Respiratory	Have you had...
☐ Allergies	☐ High/Low Blood Pressure	☐ Backache	☐ Constipation	☐ Thyroid Problems	☐Frequent Urination	☐ Difficulty Breathing	☐ Anemia
☐ Chills	☐ Chest Pain	☐ Foot Trouble	☐ Diarrhea	☐ Deafness	☐ Bed Wetting	☐ Asthma	☐ Arthritis
☐ Dizziness	☐ Heart Trouble	☐ Hernia	☐ Hemorrhoids	☐ Earache	☐ Blood in Urine	☐ Chronic Cough	☐ Cancer
☐ Fatigue	☐ Poor Circulation	☐ Pain in shoulders	☐ Nausea	☐ Blurred Vision	☐ Kidney Infection	☐ Chest Pain	☐ Diabetes
☐ Headaches	☐ Strokes	☐ Painful Tailbone	☐ Stomach Pain	☐ Frequent Colds	☐ Kidney Stones	☐ Wheezing	☐ Epilepsy
☐ Nervousness	☐ Swelling	☐ Stiff Neck	☐ Vomiting	☐ Nose Bleeds	☐ Painful Urination		☐ Heart Disease
☐ Night Sweats	☐ Varicose Veins	☐ Spinal Curvature	☐ Heart Burn	☐ Pain in Eyes	☐ Prostate Trouble		☐ HIV Positive
		☐ Swollen Joints	☐ Acid Reflux	☐ Sinusitis	**Skin**	**Females Only**	☐ Measles
		☐ Tremors		☐ Tonsillitis	☐ Bruises easily	☐ Cramps	☐ Mental Disorder
					☐ Eczema	☐ Hot Flashes	☐ Pleurisy
					☐ Hives/Allergies	☐ Pregnant Now?	☐ Polio
					☐ Itching	Due Date: _____	☐ Tuberculosis