SHEPHARD CHIROPRACTIC

Confidential Patient Information

Name ______________________ Sex ______ Marital status ______
First Middle inital Last

Date of birth __________ Age ______ Home phone ( ) __________ Social security # __________

Address __________ City __________ State ______ Zip code ______

Work phone# ( ) __________ __________
Company name Address

__________ Your email # __________
Spouse's first & last name Spouse's employer

Name of nearest relative or emergency contact __________ Phone ( ) __________

Who referred you to our office? __________

Were you referred to a certain doctor in this office? ☐ no ☐ yes If you answered "yes," to which Doctor? __________

Is your visit due to an accident? ☐ no ☐ yes If you answered yes, please notify receptionist at counter.

Have you had an auto or work related injury in the last year? ☐ no ☐ yes Date of injury? __________

Have you seen a chiropractor before? ☐ no ☐ yes Doctor's name __________

BRIEFLY DESCRIBE YOUR SYMPTOMS __________

List other doctor(s) seen for this condition __________

Medical history (if any of the following are relevant to your medical history, please check accompanying box):

☐ Heart Trouble	☐ Cancer	☐ Sinus Trouble	☐ Neck pain
☐ Concussion	☐ Muscular Dystrophy	☐ Tuberculosis	☐ Back pain
☐ Dizziness	☐ Rheumatic Fever	☐ Convulsions	☐ Headaches
☐ Arthritis	☐ Digestive Disorders	☐ Nervousness	☐ High Blood Pressure
☐ Diabetes	☐ Polio	☐ Scarlet Fever	☐ Epilepsy
☐ Hepatitis	☐ Multiple Sclerosis	☐ Numbness	☐ Asthma

Describe any operations you've had and the dates __________

Have you been treated by a physician for any health condition in the last year? ☐ no ☐ yes

Describe Condition __________ Date of last physical exam __________

Are you now taking any medication? ☐ no ☐ yes If you answered yes, what type(s)? __________

Are you pregnant? ☐ no ☐ yes First day of last menstrual period? __________

Do you have insurance coverage? ☐ no ☐ yes insurance company name? __________

Do you have secondary coverage? ☐ no ☐ yes insurance company name? __________

I.D.# __________ auto insurance co. __________ auto claim # __________

3rd party auto insurance co. __________ 3rd party claim # __________

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that the amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Shephard Clinic extends credit to me and 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, unless prior arrangements are made. I hereby authorize the Doctors of ShephardChiropractic and whomever they may designate as their assistants, to administer treatment as they deem necessary and authorize the release of any information acquired in the course of my examination, treatment or payment. I certify that the above information is true and correct.

PATIENT (or Parent or Guardian's) SIGNATURE __________ Date __________

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patient questionaire

Have you experienced any of the following symptoms?								Doctor only: OFDI
1.	HEADACHES	☐ yes	☐ no	if yes, when?	☐ past	☐ present		
2.	DIZZINESS	☐ yes	☐ no	if yes, when?	☐ past	☐ present		
3.	BLURRED VISION	☐ yes	☐ no	if yes, when?	☐ past	☐ present		
4.	LOSS of CONCEN.	☐ yes	☐ no	if yes, when?	☐ past	☐ present		
5.	DEPRESSION	☐ yes	☐ no	if yes, when?	☐ past	☐ present		
6.	NERVOUSNESS	☐ yes	☐ no	if yes, when?	☐ past	☐ present		
7.	DIFFICULT SLEEP	☐ yes	☐ no	if yes, when?	☐ past	☐ present		
8.	LOSS of ENERGY	☐ yes	☐ no	if yes, when?	☐ past	☐ present		
9.	TIRED in a.m.	☐ yes	☐ no	if yes, when?	☐ past	☐ present		
10.	BUZZ/RING/EAR	☐ yes	☐ no	if yes, when?	☐ past	☐ present		
11.	RUN DOWN	☐ yes	☐ no	if yes, when?	☐ past	☐ present		
12.	FAINTING	☐ yes	☐ no	if yes, when?	☐ past	☐ present		
13.	PALPITATIONS	☐ yes	☐ no	if yes, when?	☐ past	☐ present		

Have you had any problems with the following... ?							general
14.	HEAD	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
15.	SINUS	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
16.	NECK PAIN or stiffness	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
17.	SHOULDER	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
18.	ARM PAIN (R/L)	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
19.	UPPER BACK	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
20.	MID-BACK	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
21.	CHEST PAIN	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
22.	LUNG	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
23.	HEART	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
24.	STOMACH	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
25.	DIGESTION	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
26.	BLADDER	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
27.	LIVER	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
28.	KIDNEY	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
29.	COLON	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
30.	CONSITPATION	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
31.	LOW BACK	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
32.	HIP	☐ yes	☐ no	if yes, when?	☐ past	☐ present	
33.	LEG PAIN	☐ yes	☐ no	if yes, when?	☐ past	☐ present	

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certification of non-pregnant

The purpose of this form is to protect against any unecessary harm that could potentially occur to an unborn child. I understand that there is a potential risk of damage or defect to an unborn child exposed to X-ray radiation. I hereby state that I am not pregnant. I have been told that, if there is the smallest chance that I am pregnant, I should delay this

patient signature

date

consent to treat minor

I hereby authorize the Doctors at ShephardFox Clinic and whomever they may designate as assistants to administer chiropractic care as deemed necessary to:

name of child

indicate relationship to child

signature of parent or guardian

witness *date*