Reinen Beyler
CHIROPRACTIC, LLC

## CONFIDENTIAL PATIENT INFORMATION

Date ___/ ___/ ___ First Name _____ MI ____ Last Name_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Email _____

Male ___ Female ___ Age _____ Birth Date ___ / ___ / ___ Marital Status: M S W D

Names and ages of children _____

Occupation _____ Employer _____

Name of Spouse/Partner _____ Employer_____

In case of emergency- Name_____ Phone _____

Referred by _____ (friend, relative, coworker, insurance, internet)

Would you like appointment text reminder? Yes ____ No ____ Cell Phone Carrier _____

Would you like appointment email reminders? Yes ____ No ____

Last 4 Digits of Social Security Number _____ (for sign in computer)

Purpose of this appointment _____

Other doctors you have seen for this condition _____

Have you been treated for any health condition in the last year? YES NO (circle one)

Describe _____

Family Physician _____ Allergies _____

Medications I am presently taking _____

_____

### Insurance Information

Insurance Carrier _____ Policy Holder _____ Birth Date ____/____/____

Employer_____ Relation to Patient _____

**If you are using insurance, Reinen Beyler Chiropractic will file your insurance for you.**

**Health insurance policies are agreements between you and your insurance company. You are responsible for charges for the services provided to you regardless of how your insurance company responds.**

**I understand that deductibles, co-insurance and co-payments are due at the time service is rendered.**

**There is a charge for not canceling appointments. A monthly late fee will be charged for each month no payments are made.**

**Patient's Signature**_____

Name _____

**Please check any of the following conditions you have had in the past or are experiencing presently.**

| | | Past | Presently |
|---|---|---|---|
| 1. | Dizziness | ☐ | ☐ |
| 2. | Backaches | ☐ | ☐ |
| 3. | Heart Trouble | ☐ | ☐ |
| 4. | Diabetes | ☐ | ☐ |
| 5. | Tuberculosis | ☐ | ☐ |
| 6. | Arthritis | ☐ | ☐ |
| 7. | Headaches | ☐ | ☐ |
| 8. | Asthma | ☐ | ☐ |
| 9. | Neuritis | ☐ | ☐ |
| 10. | Digestive Disorders | ☐ | ☐ |
| 11. | Nervousness | ☐ | ☐ |
| 12. | Sinus Trouble | ☐ | ☐ |
| 13. | Anemia | ☐ | ☐ |
| 14. | Cancer | ☐ | ☐ |
| 15. | Neck Pain | ☐ | ☐ |
| 16. | Skin Conditions | ☐ | ☐ |
| 17. | Hypertension | ☐ | ☐ |
| 18. | Deep Vein Thrombosis | ☐ | ☐ |
| 19. | Other Vascular Conditions | ☐ | ☐ |

_____

**HEALTH HABITS**

Glasses of water consumed per day _____

Number of fruits/vegetables consumed per day _____

Please list any supplements you are currently taking _____

_____

Do you smoke? ___ No ___ Yes ____ packs/week

Do you drink alcohol? ___ No ___ Yes ____ drinks/week

Do you drink soda? ___ No ___ Yes ____ cans/week

**LIFESTYLE**

Job Description (work activities) _____

Work Schedule _____

What are your hobbies? _____

How regularly do you exercise? ( ) ___ x/week

What kind of exercise do you do? _____

_____

How many hours of sleep do you get on average? _____

Please rank your pain level:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Sharp Pain

Mark the areas on your body of your main complaint. Please use the appropriate symbols:

Burning xxx
Dull Pain +++
Numbness ===
Pins & Needles ooo
Sharp pain ###
Shooting ***
Stabbing ///