Reinen Beyler
CHIROPRACTIC, LLC

CONFIDENTIAL PATIENT INFORMATION

Date ___/ ___/ ___

First Name _____ MI ____ Last Name_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Email _____

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

Occupation _____ Employer _____

Name of Spouse/Partner _____

Employer_____

Names and ages of children _____

Emergency Contact _____ Phone _____ Relationship _____

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 _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT. THANK YOU.

Name of person responsible for payment _____

Are you insured? _____ Yes _____ No Company _____

Patient's Signature _____ Date _____

Guardian Signature _____ Date _____

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 ///