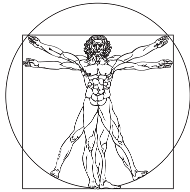
STOVER CHIROPRACTIC CENTER



PATIENT INFORMATION

Name ______________________________

Date ____________ Sex ☐M ☐F Age ________

Address ______________________________

City ________________,TX. Zip __________

Email ______________________________

☐ Married ☐ Single ☐ Minor

Occupation ______________________________

Employer ______________________________

Work Address ______________________________

____

Work Phone Number ______________________________

Spouses Name ______________________________

Who Referred You? ______________________________

PHONE NUMBERS

Cell Phone ______________________________

Home Phone ______________________________

Best Time To Reach You ______________________________

IN CASE OF EMERGENCY CONTACT

Name ______________________________

Relationship ______________________________

Phone ______________________________

INSURANCE

Who is responsible for this account? ______________________________

Relationship to Patient ______________________________

Insurance Company ______________________________

Group # ______________________________

Subscribers Name ______________________________

Birthdate ____________ SS# ______________________________

Relationship to Patient ______________________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents, have insurance coverage with ____________________ and assign directly to Dr. Stover and Stover Health Centers P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges as they are recieved unless other arrangements have been made in advance.

I authorize the use of my signature on all insurance submissions. I authorize the release of any medical information necessary to process this insurance claim. I give my permission for Stover Chiropractic Center to notify me by phone. This consent will end one year from the date below.

____
signature of patient, parent or guardian

____
please print name of patient, parent or guardian

____________________ ____________________
date relationship to patient

ACCIDENT INFORMATION

Is this condition due to an accident? ☐Yes ☐No

Date of accident ______________________________

Type of accident: ☐Auto ☐Work ☐Home ☐Other

Attorneys Name (if applicable)

____

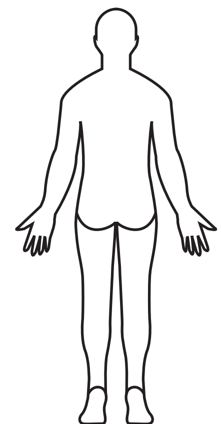
PATIENT CONDITION

Reason For Visit ______________________________

When did your symptoms begin ______________________________

Have your symptoms gotten worse? ______________________________

Mark an X on the diagram to the right where you continue to have pain



Rate the severity of your pain on a scale from 1 (least pain) to 9 (most pain) __________

Type of pain: ☐Sharp ☐Dull Ache ☐Throbbing ☐Shooting ☐Numbness/Tingling

How often do you have this pain ______________________________

Is it constant or does it come and go ______________________________

Does it interfere with your ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Activities that are painful to perform ☐ Sitting ☐ Walking ☐ Bending ☐ Lying Down

- over -

HEALTH HISTORY

What treatments have you already received for your condition? ☐ Surgery ☐ Physical Therapy ☐ Chiropractic
☐ Medications ☐ None ☐ Other ______________________________

Name and address of other doctors who have treated you for this condition ______________________________

Date of last: Physical Exam ____________ XRay ____________ MRI, CT, Bone Scan ____________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabletes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problem	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking — Packs/Day ____________
☐ Alcohol — Drinks/Week ____________
☐ Coffee/Caffeine — Cups/Day ____________
☐ High Stress — Reason ____________

Are you pregnant? ☐ Yes ☐ No Due Date ______________________

Injuries/Surgeries you have had:	Description	Date
Falls	______________________	____________
Head Injuries	______________________	____________
Broken Bones	______________________	____________
Dislocations	______________________	____________
Surgeries	______________________	____________

MEDICATIONS	ALLERGIES	VITAMINS
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________