Welcome to Flex Medical Centers

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Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. (Please Print)

Name____Date_________
First MI Last
Address____City__________State___Zip_____
Birth Date___/___/_____Sex: ❒ Male ❒Female
Do you prefer to receive calls at: ❒Home ❒Work ❒ Cell (mark all that apply)
Home#:______________________Cell #:________________________Work#:________________
Email address:____
Are you: ❒Minor ❒Married ❒Divorced❒ Widowed ❒Single ❒Separated
Your Employer__________________________________Occupation__________________________
Spouse's or Parent's Name ____
Person to contact in case of emergency______________________________Phone#
____

Insurance Information

Name of Insured________________________________Relationship to Patient ________________
Birth Date__________________________Insurance Co.___________________________________
Phone# ( )__________________Group#__________________ID # _____________________
DO YOU HAVE ADDITIONAL INSURANCE? ❒No ❒Yes
IF YES: Name of Insured ___________________________Relationship to Patient_______________
Birth Date_________________________Insurance Co.___________________________________
Phone# ( ) __________________Group#_________________ID# ______________________

Symptoms

Reason for visit ____
___________________________When did you first notice the symptoms?__________________
Is this condition getting progressively worse? Y / N Where specifically is the problem(s) located?
____

Which activities are difficult to perform? ❒ Sitting ❒Standing❒Walking ❒Bending
❒ Lying Down ❒Other ____
Type of Pain: ❒Sharp ❒Dull ❒Throbbing ❒Numbness ❒Aching ❒Shooting
❒Burning ❒Tingling ❒Cramps ❒Stiffness ❒Swelling ❒Other _________________________
Rate of severity of your pain. (1, mild pain to 10, severe pain): 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go? ____
What treatment have you already received for your condition? ❒Medication ❒Surgery
Physical Therapy ❒Other ____
Name of other doctor(s) who have treated you for your condition: ____________________________

Accident Information

Is condition due to an accident? ❒ Yes ❒ No If yes, Date of Accident__________

Type of Accident ❒ Auto ❒ Work ❒ Home ❒ Other_____________________________________

Health History

Check only those conditions which are applicable:

❒ AIDS/HIV	❒ Cataracts	❒ Hepatitis	❒ Osteoporosis	❒ Suicide Attempt
❒ Alcoholism	❒ Chemical Dependency	❒ Hernia	❒ Pacemaker	❒ Thyroid Problems
❒ Allergy Shots	❒ Chicken Pox	❒ Herniated Disc	❒ Parkinson's Disease	❒ Tonsillitis
❒ Anemia	❒ Depression	❒ Herpes	❒ Pinched Nerve	❒ Tuberculosis
❒ Anorexia	❒ Diabetes	❒ High Cholesterol	❒ Pneumonia	❒ Tumors, Growths
❒ Appendicitis	❒ Emphysema	❒ Kidney Disease	❒ Polio	❒ Typhoid Fever
❒ Arthritis	❒ Epilepsy	❒ Liver Disease	❒ Prostate Problems	❒ Ulcers
❒ Asthma	❒ Fractures	❒ Measles	❒ Prosthesis	❒ Vaginal Infection
❒ Bleeding Disorders	❒ Glaucoma	❒ Migraine Headaches	❒ Psychiatric Care	❒ Venereal Disease
❒ Breast Lump	❒ Goiter	❒ Miscarriage	❒ Rheumatoid Arthritis	❒ Whooping Cough
❒ Bronchitis	❒ Gonorrhea	❒ Mononucleosis	❒ Rheumatic Fever	❒ Other __
❒ Bulimia	❒ Gout	❒ Multiple Sclerosis	❒ Scarlet Fever	______________
❒ Cancer	❒ Heart Disease	❒ Mumps	❒ Stroke	______________

Dates of last exams____

(Women) Are you pregnant? ❒ Yes ❒ No Taking birth control pills? ❒ Yes ❒ No

List any types of surgeries which you have had and the dates which they occurred:

____

Please list all medications you are currently taking

____

Allergies:

____

Daily Habits

What type of exercise do you perform on a daily basis? ❒ None ❒ Moderate ❒ Heavy

What do your daily work habits include? ❒ sitting, ❒ standing, ❒ light labor, ❒ heavy labor, ❒ computer work, ❒ other____

What vitamins do you currently take?____

What kind of other nutritional supplements do you take (if any)? ______________________

Do you smoke? ❒ Yes ❒ No If yes, how much per day/week?________________________

How much liquor do you consume on a weekly basis?

____

How much coffee or caffeinated beverages do you consume on a daily basis?

____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

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SIGNATURE OF PATIENT (or parent if a minor) DATE