Welcome to Chiropractic and Rehab of Cheshire | *Date:*

Patient Information

Patient Name: ______________________________

Address: ___________________________________

City: ______________________________________

State: _________________Zip: _______________

Home Phone: (______) ____________________

Cell Phone: (______) ______________________

Best time to reach you: ____________________

Email: ____________________________________

Birthdate: _____/______/______ Age: _______

Sex: ☐ Male ☐ Female

☐ Married ☐ Single ☐ Widowed ☐ Divorced

Patient Employer/School: ___________________

Address:___________________________________

Employer Phone:____________________________

Occupation: ________________________________

Who can we than k for referring you? ___________

In Case of Emergency Contact:

Name: ________________________________

Phone: ________________________________

Relationship:___________________________

Insurance Information

Primary Insurance: _____________________

Secondary Insurance:___________________

Subscribers Name: _____________________

Subscribers D.O.B: _____________________

I certify that I and/or my dependent(s) have insurance coverage and assign directly to CRC all insurance benefits. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature: _____________________________

Date: __________________________________

Accident Information

Is this visit related to an accident? ☐ YES ☐ NO Accident Date: _____________________________

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other Attorney Name: ___________________________

Health History

Describe any health problems and how long you've had them: _______________________________________

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Current Medications: ____

Past surgeries & dates: ____

Usinga scale from 1 to 10 please rate your health: ____

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Chiropractic History

Have you ever been to a chiropractor before? _______________ Dr.'s Name: ____________________________

Date of last chiropractic visit: ____________________________ Reason for care:_________________________

Please check the following if applicable. ☐ Xrays ☐ MRI ☐ CT Scan

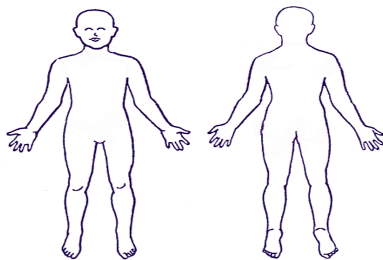
Patient Condition

Reason for Visit: ____

When did your symptoms appear: ____

Is your condition getting progressively worse? ____

Please mark an "X" on the diagram to indicate where you have pain, numbness, or tingling.



Using a scale of 1 to 10, rate the severity of your pain.

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐Shooting

☐ Burning ☐ Tingling ☐Cramping ☐Stiffness ☐Swelling ☐ Other

How often do you have this pain? ____

Is it constant or does it come and go? ____

Does it interfere with ☐ Work ☐ Sleep ☐ Daily Routine ☐Recreation/Exercise

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending

☐ Lying Down ☐ Driving ☐ Personal Care ☐ Other

Any other health information you feel the doctor might need for your care: ______________________________

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