Welcome to Sippl Chiropractic Clinic

ABOUT YOU

Patient Name: ___________________________ Preferred name _________Date ______________

MailingAddress: ____

City State Zip Code

Employer: ____________________________________Occupation: __________________

Phone: (Home) ______________ (Cell) __________________(Work)______________

E-mail Address: ____

Birthdate: _____/_____/_____ Age: _______ SS#: __________________

Marital Status: Married / Single / Divorced / Widowed

Spouse's Name: _______________ Phone: _________________ Children: Yes / No How many? ______

Who we can we thank for referring you?____

What are your hobbies/interests?____

____

EMERGENCY INFORMATION

Whom should we contact? ____

Relationship: ________________________________ Phone: ____________________

Who is your medical doctor? ________________ Phone: ___________________________

REASON FOR YOUR VISIT

Reason for today's visit: Emergency New Injury Old Injury Chronic pain Wellness

Are you in pain now? Yes No When did the problem start? ______________________

How did it happen? ____

How is it progressing? Improving Same Getting worse

Did your injury occur at: Work Auto accident Home Other

How Frequent are your symptoms? Occasional Intermittent Frequently Constant

Does your condition interfere: Work Daily routine Sleep

If so, how? ____

Have you had this or a similar condition in the past? Yes No

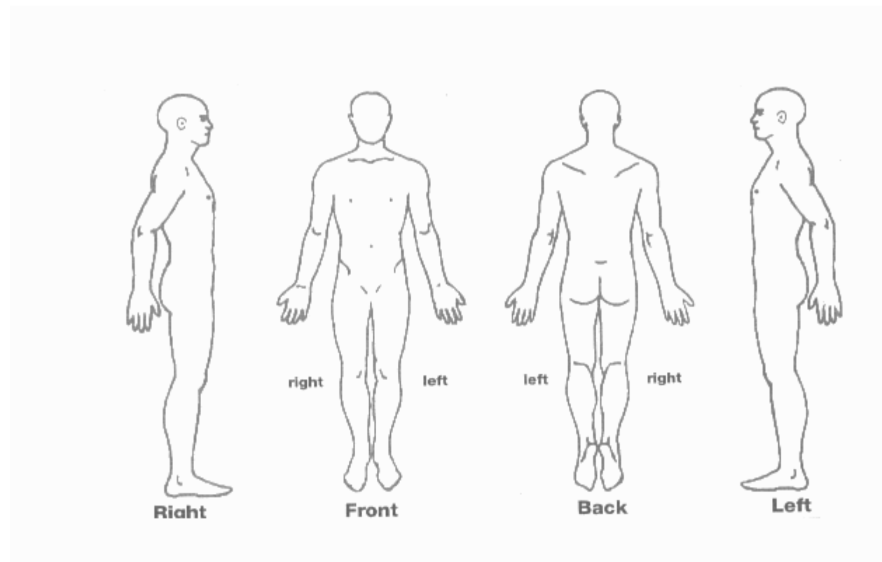
Explain: ____

Using the adjacent body Charts, please circle all affected areas
List if it is S,B,A, N or/and P and the number affiliated with the pain chart

S=Stabbing
B=Burning
A=Aching
N=Numbing
P=Pins and Needles

On a Pain scale of 1-10

1 being no pain and
10 being extreme pain



HEALTH HISTORY

Do you or have you had any of the following diseases, medical conditions or procedures? Please **circle**

Heart/Surgery Hepatitis HIV/AIDS Thyroid Alcohol/Drug Abuse
Cancer/Chem Diabetes Osteoporosis Seizures Anemia/Blood Disorders
Psychiatric issues Sinus/Allergies Lung/TB Stroke/TIA Difficulty breathing/Asthma
High Cholesterol Foot/Ankle CTS/wrist Jaw pain/clicking RA/Osteoarthritis
Earaches/infection Headaches/Migraines Numbness in limbs Artificial joint/limbs
Stomach pain Dizziness/nausea Fatigue/sleep apnea

Please list any surgeries with dates and or other medical conditions______________________________
____

Please list any serious accidents ____
____

Please list any medications/ nutritional supplements that you are taking? _________________________
____
____

As a child, what injuries/accidents did you sustain. (ie:car, sport, falls, broken bones/sprains, etc) _____
____

Did you participate in any youth sports? Y N please list_______________________________________

Women: Is there any chance you might be pregnant? Yes No Not sure
Are you taking birth control? Yes No Nursing? Yes No

FAMILY HISTORY

Please check any of the following conditions that run in your family and indicate accordingly: **F**ather **M**other **S**ister **B**rother

_____ Heart Condition/Stroke _____ High/Low Blood Pressure _____ Sinus Problems
_____ Digestive Condition _____ Diabetes _____ Migraines
_____ Cancer _____ Asthma _____ Psychiatric Problems
_____ Arthritis _____ Artificial Joints _____Neck/Back pain

At Sippl Chiropractic we are not only interested in your health, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about:

Spouse: ____
Children: ____
Other relative:____

SOCIAL HISTORY

Have you ever been treated by a chiropractor? Yes / No Clinic Name: ___________________When?_________
Do you smoke? Yes No How long? ___________ How much? ________________
Do you exercise? Yes No ____hours per week
Have you ever worn? Heel lifts Arch supports Orthotics Explain:________________________________

- We invite with you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I provided.

____ _________________
Signature: Adult Patient / Parent or Guardian / Spouse Date