

TUCKER CHIROPRACTIC CENTER
PO BOX 936 – GENTRY, AR 72734
479-736-8900

Patient's Name: _____ Sex: M / F ID# _____

Date of Birth: _____ Social Security: _____ Marital Status: M S W D

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address (if different): _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Preferred way to be contacted: Home or Cell May we leave a message for you? Y/N

In case of emergency, who should we contact? _____

Relationship: _____ Phone #: _____

Employer: _____ Job Title: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Spouse's Name: _____ Date of Birth: _____

Spouse's Social Security #: _____ Phone #: _____

Spouse's Employer: _____ Work Phone #: _____

Reason for this visit: _____

How and when did your symptoms begin? _____

Who referred you to our office? _____

When was your last chiropractic treatment? _____

Reason: _____

When was your last spinal x-ray? _____

Name of your Medical Physician: _____

Are you presently under the care of your Medical Physician? Yes / No

Reason: _____

When did you last have a physical exam? _____

Drug Allergies: _____

Adverse reaction to allergy: _____

Please list any medications or vitamins you take: _____

Please list any severe illnesses and dates: _____

Please list any car accidents, surgeries, hospitalizations, falls or other traumas and dates:

TUCKER CHIROPRACTIC CENTER
PO BOX 936 – GENTRY, AR 72734
479-736-8900

Patient's Name: _____ DOB: _____ ID #: _____

Have you ever been diagnosed as suffering from any of the following? (Please check)

- | | | |
|--|---|--|
| <input type="checkbox"/> Broken or Fractured Bones | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Seizures / Convulsions | <input type="checkbox"/> Strokes | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> A Congenital Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ruptures | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Spinal disc disease |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Polio | <input type="checkbox"/> STD's | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bone disease | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Diverticulitis |

Do you have a family history of any of the following? (Please check)

- | | | |
|--|---|--|
| <input type="checkbox"/> Strokes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Bone fractures |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Spinal disc disease |

Please explain anything checked: _____

Would you like us to share your medical information with anyone? ___ Yes ___ No
Who? _____

Would you like to share your financial account information with anyone? ___ Yes ___ No
Who? _____

All information that has been given is current and true to my knowledge. I understand that it is my responsibility to notify Tucker Chiropractic Center of any changes to my insurance information, and not doing so could result in balances being my responsibility. I have read the missed appointment policy and understand that not cancelling my appointment in a timely manner will result in a \$15 charge.

I hereby give Tucker Chiropractic Center consent to treat me, and I understand that I am personally responsible for payment of services rendered. I have been offered a copy of the HIPPA Notice of Privacy Practices that was provided by this office, and understand its terms.

Signature: _____ Date: _____

TUCKER CHIROPRACTIC CENTER
PO BOX 936 – GENTRY, AR 72734
479-736-8900

INITIAL VISIT HISTORY

Name _____ BIRTHDATE _____ ID# _____

CHIEF COMPLAINT: _____

HISTORY OF PRESENT ILLNESS

How and when did symptoms begin? _____

On a scale of 0-10 (*with 10 being the worst*), rate the pain you currently experience in your:
___ Neck ___ Mid back ___ Low back ___ Other _____

Check all that apply:

When is your pain the worst? ___ Morning ___ Afternoon ___ Night

What does your pain interfere with? ___ Work ___ Sleep ___ Daily Routine ___ Recreation

What activities aggravate your pain? ___ Sitting ___ Standing ___ Walking ___ Bending
___ Lying down ___ Driving ___ Lifting

Are you experiencing any? ___ Numbness ___ Tingling ___ Radiating pain ___ Burning
___ Aching ___ Tenderness ___ Edema ___ Muscle spasms

Have you seen another doctor for this condition? Yes / No

If so, who and when? _____

Does anything help to relieve your symptoms? Yes / No

If so, what? _____

Secondary complaints (Any other complaints): _____

Do you smoke? _____ How much a day? _____ Drink alcohol? _____ How often? _____

Do you use any other substances? _____ If so, what and how often? _____

Special Diet? _____

Exercise? _____

Occupation/Recreation? _____

Any and all information that is recorded on this page is true to my knowledge. I have discussed any issues with Dr. Tucker or his staff and have no contraindications to chiropractic care.

Patient

C.A.

Chiropractor

Date