Tucker Chiropractic Center
& Wellness Center

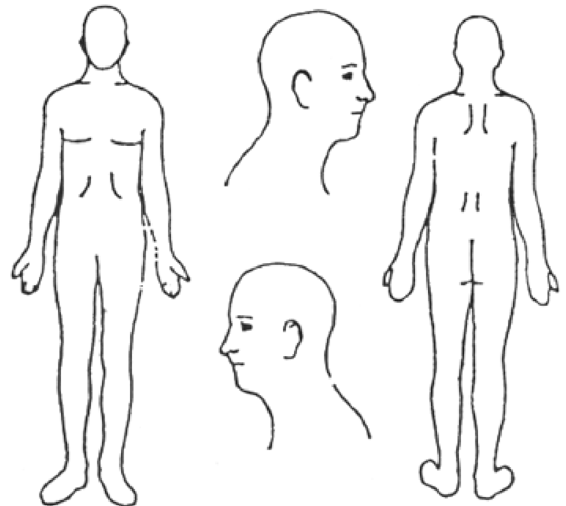
198 N. Pine Street Langhorne, PA 19047
Phone: (215) 750-8006 Fax: (215) 750-8007

CONFIDENTIAL PATIENT INFORMATION

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to disciplines we believe will help you. In order for us to understand your health problems, please complete this form neatly, accurately, and completely. Thank You.

Full Name ______________________________ Birth date ____________ Age _____ Sex M / F
Address ______________________________________ SS# ______________
Phone: Home _____________ Cell ________________ E-mail ____________________
Status (check one): Single □, Married □, Widowed □, Divorced □, Separated □. Children: # _____, ages ________
Occupation __________________ Employer _______________ Supervisor ______________
Work address ____________________________________ Work phone ______________
Spouse / Parent __________________________________ Birth date ______________
In case of Emergency contact: ________________ Relation ________ Phone ______________
Medical Doctor ___________________________________ Phone ______________
Doctor's address ____
How did you hear about our office? ____________________________________
Have you ever been to a Chiropractor? Y / N Last visit date ____________________
Describe results: ____
LIST COMPLANTS: ______________________________
____
____

Please mark your areas of pain on the figures below



PAIN LEVEL: RATE THE INTENSITY OF YOU PAIN
(circle the number)

0	1	2	3	4	5	6	7	8	9	10
No Pain		Low Pain			Moderate Pain			Intense Pain		Excr. Pain

WHICH OR THE FOLLOWING ACTIVITIES
WORSEN YOUR CONDITION?
Nothing □, Lifting □, Getting-up □, Standing □, Walking □,
Sitting □, Movement □, Inactivity □, Work □, Exercise □.
IMPROVE YOUR CONDITION?
Nothing □, Standing □, Walking □, Sitting □, Movement □, Sleep □,
Exercise □, Inactivity □, Lying down □, Stretching □,
Hot Shower/Bath □.
SYMPTOMS ARE WORSE: AM □, MIDDAY □, PM □.
ARE THERE ANY ACTIVITIES THAT YOUR CONDITION INTERFERES WITH?
GIVE DETAILS: ____
IS YOUR CONDITION DUE TO *AN* ACCIDENT / FALL / ILLNESS / OTHER?
GIVE DETAILS: ____
____
____

List other Doctor(s) consulted for present complaints and injuries:
Name ____________________ Type of Doctor ______________ When consulted __________
Treatments / x-rays ______________________ Diagnosis ____________________
How long did you see the Doctor? _______________ How frequently? ______________
Results: ____

Patient Name ____
Name _________________________ Type of Doctor _______________ When consulted __________
Treatments / x-rays ______________________________ Diagnosis __________________________
How long did you see the Doctor? ______________________ How frequently? _____________________
Results: ____

PAST MEDICAL HISTORY

List any medical conditions you have ever had / have and dates: ________________________________
____
List any surgeries you have had and give dates: ____
____
Broken Bones: Which / When / Remarks: ____
____
List other accidents or serious falls: (auto, work home; leisure, sports, other) What / When / Treatment / Results:
____
For Women: Are you pregnant? Y / N First date of last menstrual cycle ___________________________
List all medications you are now taking: ____
____
List all vitamins and supplements you are now taking: ____
____
Do you have a back brace? Y / N Is your pillow Comfortable? Y / N
How do you sleep? stomach □, side □, back □.

INSURANCE INFORMATION

Insurance company __________________________________ ID#: __________________________
Subscriber's name __________________________________ Birth date _______________________
Address ____ SS# __________________________

ASSIGNMENTANDRELEASE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I here by authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature ____ *Date* ______________

Consent to Treat a Minor _______________________________________ *Date* ______________

Guardian or Spouse's
Signature of Authorizing Care ___________________________________ *Date* ______________