

# GALLATIN CHIROPRACTIC CLINIC

Mark B. Groff B.S., D.C

1167 Nashville Pike Gallatin, TN 37066 (615) 451-3400

Patient Full Name (First Middle Last): \_\_\_\_\_ Social Security#: \_\_\_\_\_

Patient Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient Cell # \_\_\_\_\_ Work# \_\_\_\_\_ Home# \_\_\_\_\_

Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Marital Status (Circle One): S M W D SEP If Student: (FT or PT) Name of School: \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Employer # \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Responsible Party for Payment of Account (First Middle Last): \_\_\_\_\_

Responsible Party Employer: \_\_\_\_\_ Employer's #: \_\_\_\_\_

Name of Spouse or Responsible Party: \_\_\_\_\_ Spouse Employer or School: \_\_\_\_\_

Spouse's Employers Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Employer #: \_\_\_\_\_ Cell# \_\_\_\_\_ Occupation: \_\_\_\_\_

Next of Kin To Notify In Case of Emergency Who Does Not Live In Your Household:

Name (First Middle Last) \_\_\_\_\_ Phone# \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone# \_\_\_\_\_ Seen Last: \_\_\_\_/\_\_\_\_/\_\_\_\_

Family Physician: \_\_\_\_\_ Phone# \_\_\_\_\_ Seen Last: \_\_\_\_/\_\_\_\_/\_\_\_\_

Other Chiropractor: \_\_\_\_\_ Phone# \_\_\_\_\_ Seen Last: \_\_\_\_/\_\_\_\_/\_\_\_\_

Who referred you to our office? \_\_\_\_\_

## INSURANCE INFORMATION

Insurance Company Name (Policy 1): \_\_\_\_\_ ID# \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Insured: Self/Spouse/Child/Other Group # \_\_\_\_\_

Insurance Company Name (Policy 2): \_\_\_\_\_ ID# \_\_\_\_\_

Named of Insured: \_\_\_\_\_ Relationship to Insured: Self/Spouse/Child/Other Group# \_\_\_\_\_

Workman's Compensation or Auto Accident Related? \_\_\_\_ Yes \_\_\_\_ No If so, date of injury \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Signature: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# Gallatin Chiropractic Clinic

Mark B. Groff B.S., D.C.

1167 Nashville Pike Gallatin, TN 37066 (615) 451-3400

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Describe your symptoms: \_\_\_\_\_

When did your symptoms start? \_\_\_\_\_

How did your symptoms begin? \_\_\_\_\_

How often do you experience your symptoms?

\_\_\_\_\_ Constantly (76-100% of the day)

\_\_\_\_\_ Frequently (51-75% of the day)

\_\_\_\_\_ Occasionally (26-50% of the day)

\_\_\_\_\_ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

\_\_\_\_\_ Sharp

\_\_\_\_\_ Dull ache

\_\_\_\_\_ Numb

\_\_\_\_\_ Shooting

\_\_\_\_\_ Burning

\_\_\_\_\_ Tingling

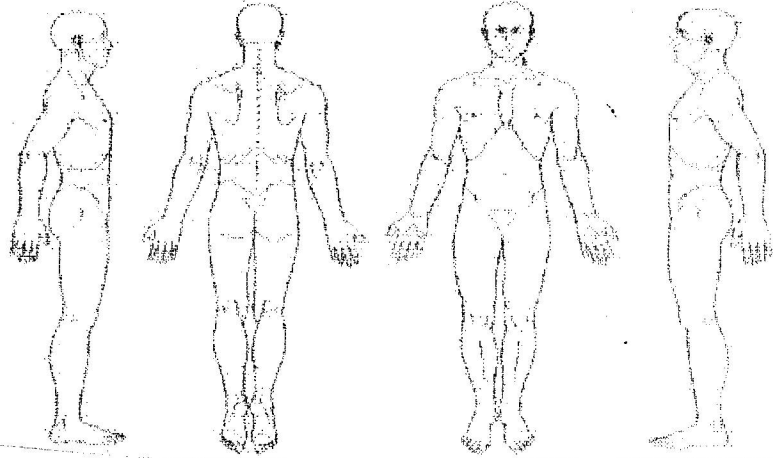
How are your symptoms changing?

\_\_\_\_\_ Getting better

\_\_\_\_\_ Not changing

\_\_\_\_\_ Getting Worse

Indicate where you have pain or other symptoms



During the past 4 weeks:

Indicate the average intensity of your symptoms

None

0

1

2

3

4

5

6

7

8

9

10

Unbearable

How much has pain interfered with your normal work (including both work outside the home and housework)

\_\_\_\_\_ Not at all

\_\_\_\_\_ A little bit

\_\_\_\_\_ Moderately

\_\_\_\_\_ Quite a bit

\_\_\_\_\_ Extremely

How much of the time has your condition interfered with your social activities?

\_\_\_\_\_ All of the time

\_\_\_\_\_ Most of the time

\_\_\_\_\_ Some of the time

\_\_\_\_\_ A little of the time

\_\_\_\_\_ None of the time

In general would you say your overall health right now is ...

\_\_\_\_\_ Excellent

\_\_\_\_\_ Very Good

\_\_\_\_\_ Good

\_\_\_\_\_ Fair

\_\_\_\_\_ Poor

Who have you seen for your symptoms? \_\_\_\_\_ No One \_\_\_\_\_ Medical Doctor \_\_\_\_\_ Other Chiropractor \_\_\_\_\_ Physical Therapist \_\_\_\_\_ Other

What treatment did you receive and When?

What tests have you had for your symptoms and when were they performed?

X-rays date: \_\_\_\_\_ CT Scan date: \_\_\_\_\_

MRI date: \_\_\_\_\_ Other date: \_\_\_\_\_

Have you had similar symptoms in the past? \_\_\_\_\_ Yes \_\_\_\_\_ No

If you have received treatment in the past for the same or similar symptoms, who did you see?

\_\_\_\_\_ This Office \_\_\_\_\_ Medical Doctor \_\_\_\_\_ Other Chiropractor \_\_\_\_\_ Physical Therapist \_\_\_\_\_ Other

Are you pregnant? \_\_\_\_\_ Yes \_\_\_\_\_ No Date of last menstrual cycle? \_\_\_\_\_

What is your occupation?

\_\_\_\_\_ FT \_\_\_\_\_ PT \_\_\_\_\_ Self-Employed \_\_\_\_\_ Unemployed \_\_\_\_\_ Off Work \_\_\_\_\_ Other

Have you tried anything for these symptoms? (heat, ice, vitamins, OTC meds, etc.) \_\_\_\_\_

List all previous surgeries: \_\_\_\_\_

List all medication, supplements, or vitamins you are taking & for what condition: \_\_\_\_\_

List all major accidents or injuries: \_\_\_\_\_

List any family history (Father, Mother, Brother/Sister, Children) such as Cancer, Heart Disease, Diabetes, etc: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_