Chiropractic First:
A Creating Wellness Center

(406) 652-6700
10 Avanta Way, Suite 1
Billings, MT 59102

Patient Information

Name _____

Address _____

City _____

State _____ Zip _____

Phone Hm _____ Wk _____

Email _____

Patient SS# _____

Birth Date _____ Age _____

Sex ☐ Male ☐ Female ☐ Minor

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Occupation _____

Employer / School _____

Employer Address _____

_____

Spouse's Name _____

Birth Date _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you?

_____

Treatment History

What treatment have you received for your condition?

☐ Chiropractic ☐ Medication ☐ Surgery

☐ Physical Therapy ☐ Massage ☐ Other _____

Name & location of other doctor(s) seen for this condition

_____

Date & location of last:

Physical Exam _____

Spinal Exam _____

MRI, CT-Scan, Bone Scan _____

Spinal X-ray _____

Are you pregnant? ☐ No ☐ Yes Due Date _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No

If yes, Date of accident: _____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Work Comp.

☐ Police ☐ Other

Patient Condition

Reason for Visit ☐ ☐ _____

_____

When did your symptoms appear? _____

Is condition getting progressively worse? ☐ Yes ☐ No

Rate the severity of your pain from **0** (least) to **10** (severe) _____

Does it interfere with your

☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are difficult to perform

☐ Sitting ☐ Standing ☐ Walking ☐ Bending

☐ Lying Down ☐ Other _____

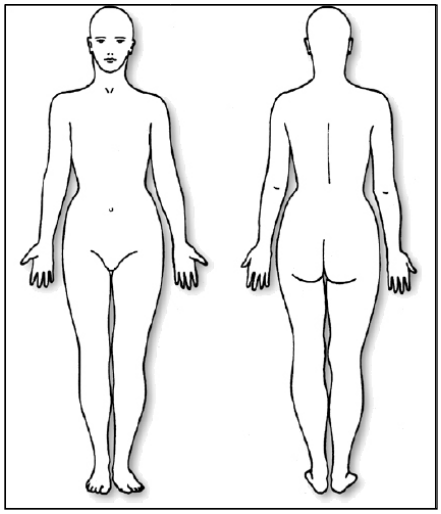
Type of pain:

☐ Sharp ☐ Throbbing ☐ Aching ☐ Burning

☐ Dull ☐ Numbness ☐ Shooting ☐ Tingling

☐ Swelling ☐ Stiffness ☐ Other _____

Mark X's on the picture where you have symptoms



Health History

☐ AIDS / HIV	☐ Cataracts	☐ Hernia	☐ Osteoporosis	☐ Suicide Attempt
☐ Alcoholism	☐ Chemical Dependency	☐ Herniated Disk	☐ Pacemaker	☐ Thyroid Problems
☐ Allergies	☐ Chicken Pox	☐ Herpes	☐ Parkinson's Disease	☐ Tonsillitis
☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Pinched Nerve	☐ Tuberculosis
☐ Anorexia	☐ Emphysema	☐ High Cholesterol	☐ Pneumonia	☐ Tumors / Growths
☐ Appendicitis	☐ Epilepsy	☐ Kidney Disease	☐ Polio	☐ Typhoid Fever
☐ Arthritis	☐ Fractures	☐ Liver Disease	☐ Prostate Problem	☐ Ulcers
☐ Asthma	☐ Glaucoma	☐ Measles	☐ Prosthesis	☐ Vaginal Infections
☐ Bleeding Disorder	☐ Goiter	☐ Migraine Headaches	☐ Psychiatric Care	☐ Venereal Disease
☐ Breast Lump	☐ Gonorrhea	☐ Miscarriage	☐ Rheumatoid Arthritis	☐ Whooping Cough
☐ Bronchitis	☐ Gout	☐ Mononucleosis	☐ Rheumatic Fever	☐ Other _____
☐ Bulimia	☐ Heart Disease	☐ Multiple Sclerosis	☐ Scarlet Fever	☐ Other _____
☐ Cancer	☐ Hepatitis	☐ Mumps	☐ Stroke	☐ Other _____

Injuries / Surgeries you have had

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Over All Health Habits
Rate yourself on a 0 to 10 scale on your:

	Past 30 Days	Past Year
Exercise		
Nutrition		
Sleep Habits		
Over All Health		

Work Activities

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Habits

- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Wk _____
- ☐ Coffee or Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Current Medications

_____ _____ _____

_____ _____ _____

Vitamins / Herbs

_____

_____

Finances

Who is responsible for this account? _____

Relationship to Patient _____ **Insurance Information:** ***Please present your insurance card to the staff at the front desk.***

I, the undersigned, assign directly to **Chiropractic First** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature	Relationship	Date