TEASEL CHIROPRACTIC CLINIC
8865 Brecksville Rd, Ste 8
Brecksville, OH 44141
(440) 736-7444

Patient ID # _____

Date _____

CONFIDENTIAL PATIENT INFORMATION

Social Security # _____

Name _____ **Home Phone** _____ **Cell Phone** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Age _____ **Birth Date** _____ **Marital Status:** ☐ Married ☐ Single ☐ Widowed ☐ Divorced # of Children _____

☐ **Male** ☐ **Female** **Height** _____ **Weight** _____ Email _____

Race/Ethnicity: ☐ Caucasian ☐ African American ☐ Asian American ☐ Hispanic/Latino ☐ Other _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Name of Wife/Husband _____ Occupation _____

Employer _____ Office Phone _____

Patient's Nearest Relative _____ Address _____

Home Phone _____ Work Phone _____

Referred by _____ **Tobacco Use** ☐ Yes ☐ No Frequency _____

Who should we contact in case of emergency? _____ Phone _____

Date of Last Physical Examination _____ Family Physician _____

Medications _____ ☐ None

Allergies _____ ☐ None

Check any of the following symptoms you have experienced in the last six months:

Dizziness	☐	Asthma	☐	Low Back Pain	☐	Pain in Legs	☐
Backaches	☐	Neuritis	☐	Pain Between Shoulder Blades	☐	Pain in Feet	☐
Heart Trouble	☐	Digestive Issues	☐	Tension across top of shoulders	☐	Difficulty sleeping	☐
Diabetes	☐	Nervousness	☐	Fibromyalgia	☐	Allergies	☐
Tuberculosis	☐	Sinus Trouble	☐	Numbness/Tingling in Arms/Hands	☐	Carpal Tunnel	☐
Arthritis	☐	Anemia	☐	Numbness Tingling in Legs/Feet	☐	Neck Pain	☐
Headaches	☐	Cancer	☐	Tired/Fatigue	☐	Tension	☐

Which of the above is the worst? _____ How long have you had it? _____

How often does it occur? _____ What does it feel like? _____

What has helped this problem? _____ What activities has this effected? _____

Does this cause you to be:
☐ Moody
☐ Irritable
☐ Interrupt Sleep
☐ Restrict Your Daily Activities

Does this effect your work:
☐ Decision Making
☐ Poor Attitude
☐ Decreased Productivity
☐ Exhausted at End of Day
☐ Unable to Work Long Hours

Does this effect your life:
☐ Lose Patience with Spouse/Children
☐ Restricted Household Duties
☐ Hinders Ability to Exercise
☐ Interferes with Hobbies/Other

Reason for Today's Appointment _____ Other Doctors seen for this Condition? _____

Have you been treated for any health condition by a Physician in the last year? ☐ Yes ☐ No Describe _____

What have you tried to help relieve this problem and how much did it help?

☐ Medications	*Helped: Little Some Much*	☐ Exercise	*Helped: Little Some Much*
☐ Physical Therapy	*Helped: Little Some Much*	☐ Nutrition	*Helped: Little Some Much*
☐ Chiropractic	*Helped: Little Some Much*	☐ Stretching	*Helped: Little Some Much*

PAYMENT IS EXPECTED AT THE TIME OF VISIT. Will you be paying today by: ☐ Cash ☐ Check ☐ Credit Card

Are You Insured? ☐ Yes ☐ No Company _____ Policy # _____

Name of Person Responsible for Payment/Policy Holder _____ Birthdate of Policy Holder _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that TEASEL CHIROPRACTIC CLINIC 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 TEASEL CHIROPRACTIC CLINIC will be credited to my account on receipt. However, I clearly understand and agree that any 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 my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____ Information Taken By _____