PATIENT INFORMATION SHEET
FAMILY CHIROPRACTIC CENTER
DR. ROBERT STALEY

Patient's Name_____ Date of Birth____/____/____ M____F____
(First, MI, Last)
What do you prefer to be called?_____ Home Phone _____Cell_____

Address_____City_____State____Zip Code_____

Marital Status: S____M____ D____W____ Age_____ Email_____

Employer's Name_____ Occupation_____

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Insurance Company_____ID#_____Group#_____

Are you the primary insured? ____Yes ____ No (if No, please complete following information)

Primary Insured_____ Date of Birth____/____/____Relationship to Patient_____

Address_____City_____State___Zip Code_____
(if different than above)
Phone_____ Employer_____

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How did you hear about our office? _____

Have you seen a chiropractor before? N / Y If yes, who and how long ago?_____

Who is your primary care physician?_____
(location)
List physicians seen for **this** condition_____

Emergency contact_____ Relationship _____

Work # _____Home # _____Cell #_____

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I understand and agree that my health and accident insurance policies are an agreement between my insurance company and myself. I clearly understand that I am responsible for those charges not covered by my insurance policy, any unmet deductible, or percentage of covered charges for which I am responsible. I agree to pay such charges at the time services are rendered. I understand that if I terminate treatment, any fees for professional services rendered to me become immediately due and payable. I authorize my insurance company to make checks directly payable to this office.

Signature:_____Date:_____

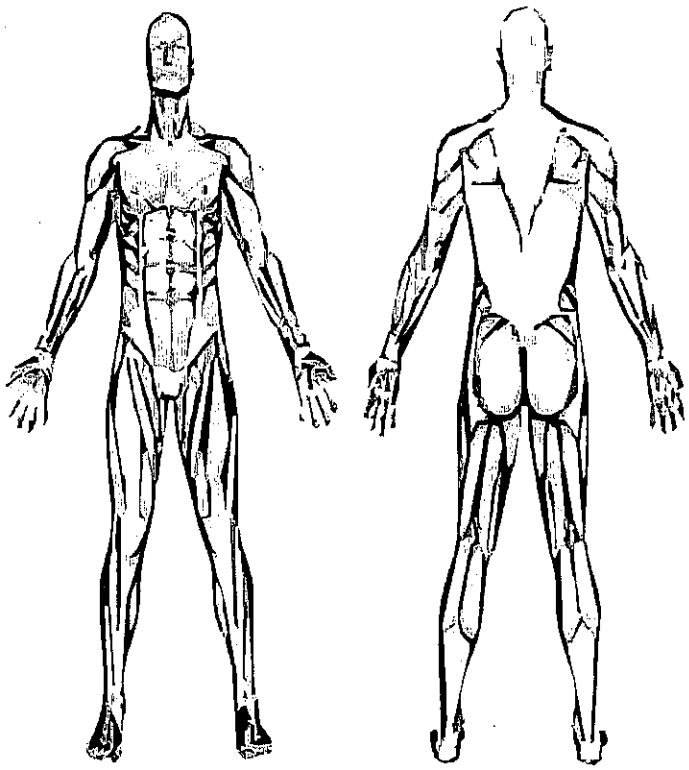
Signature of Parent/Guardian (if minor)_____

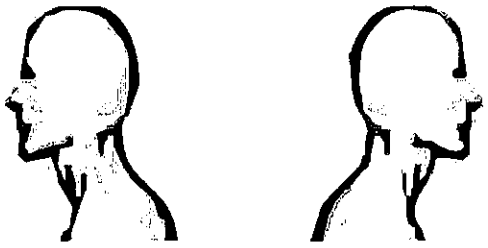
Have you ever suffered from:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing





Medical History

Have you been treated for any conditions in the last year? ○ No ○ Yes

If yes, please describe

Date of last physical exam | Is there a chance that you are pregnant? ○ No ○ Yes

Have you had X-rays taken? ○ No ○ Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)I

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	○	○	
Been hospitalized?	○	○	
Been in an auto accident?	○	○	
Had Sprains/Strains?	○	○	
Been struck unconscious?	○	○	
Had surgery?	○	○	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	○ No	○ Yes
Do your symptoms interfere with daily life?	○ No	○ Yes
Does pain wake you up at night?	○ No	○ Yes
Are your symptoms worse during certain times of the day?	○ No	○ Yes
Do changes in weather affect your symptoms?	○ No	○ Yes
Do you wear orthotics?	○ No	○ Yes
Do you take vitamin supplements?	○ No	○ Yes
What activities aggravate your symptoms?	○ No	○ Yes

Habits	None	Light	Moderate	Heavy
Alcohol	○	○	○	○
Coffee	○	○	○	○
Tobacco	○	○	○	○
Drugs	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○
Appetite	○	○	○	○
Soft Drinks	○	○	○	○
Water	○	○	○	○
Salty Foods	○	○	○	○
Sugary Foods	○	○	○	○
Artificial Sweeteners	○	○	○	○