TUCKER CHIROPRACTIC CENTER
1179 SOUTH GENTRY BLVD., GENTRY, AR 72734
479-736-8900

Patient's Name: _____ **Sex: M / F** **ID#**_____

Date of Birth: _____ **Social Security:** _____ **Marital Status: M S W D**
Mailing Address: _____
City: _____ **State:** _____ **Zip:** _____
Physical Address (if different): _____
City: _____ **State:** _____ **Zip:** _____
Home Phone #: _____ **Cell Phone #:** _____
Preferred way to be contacted: Home or Cell **May we leave a message for you? Y/ N**
In case of emergency, who should we contact? _____
Relationship: _____ **Phone #:** _____

Employer: _____ **Job Title:** _____
Employer's Address: _____
City: _____ **State:** _____ **Zip:** _____ **Phone #:**_____

Spouse's Name: _____ **Date of Birth:** _____
Spouse's Social Security #: _____ **Phone #:** _____
Spouse's Employer: _____ **Work Phone #:** _____

Reason for this visit: _____
How and when did your symptoms begin? _____
Who referred you to our office? _____
When was your last chiropractic treatment? _____
Reason: _____
When was your last spinal x-ray? _____
Name of your Medical Physician: _____
Are you presently under the care of your Medical Physician? Yes / No
Reason: _____
When did you last have a physical exam? _____
Drug Allergies: _____
Adverse reaction to allergy: _____
Please list any medications or vitamins you take: _____
_____
_____
_____
Please list any severe illnesses and dates: _____
_____
_____

Please list any car accidents, surgeries, hospitalizations, falls or other traumas and dates:
_____
_____
_____
_____

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Patient's Name: _____ **DOB:** _____ **ID #:** _____

Have you ever been diagnosed as suffering from any of the following? (Please check)

____ Broken or Fractured Bones	____ Osteoarthritis	____ Eating Disorder
____ Circulatory Problems	____ Epilepsy	____ Alcoholism
____ Rheumatoid Arthritis	____ Pace Maker	____ Drug Addiction
____ Seizures / Convulsions	____ Strokes	____ HIV Positive
____ A Congenital Disease	____ Cancer	____ Gallbladder
____ High Blood Pressure	____ Ulcers	____ Headaches
____ Low Blood Pressure	____ Ruptures	____ Depression
____ Osteoporosis	____ Diabetes	____ Excessive Bleeding
____ AIDS	____ Anemia	____ Kidney trouble
____ Thyroid trouble	____ Tuberculosis	____ Spinal disc disease
____ Scoliosis	____ Multiple sclerosis	____ Prostate problems
____ Polio	____ STD's	____ Stroke
____ Bone disease	____ Lung disease	____ Diverticulitis

Do you have a family history of any of the following? (Please check)

____ Strokes	____ Liver Disease	____ AIDS
____ High Blood Pressure	____ Anemia	____ Arthritis
____ Low Blood Pressure	____ Kidney Disease	____ Bone fractures
____ Heart Disease	____ Tuberculosis	____ Multiple sclerosis
____ Cancer	____ Diabetes	____ Spinal disc disease

Please explain anything checked: _____

_____

_____

_____

Would you like us to share your medical information with anyone? ____ **Yes** ____ **No**
Who? _____

Would you like to share your financial account information with anyone? ____**Yes** ___ **No**
Who? _____

All information that has been given is current and true to my knowledge. I understand that it is my responsibility to notify Tucker Chiropractic Center of any changes to my insurance information, and not doing so could result in balances being my responsibility. I have read the missed appointment policy and understand that not cancelling my appointment in a timely manner will result in a $15 charge.

I hereby give Tucker Chiropractic Center consent to treat me, and I understand that I am personally responsible for payment of services rendered. I have been offered a copy of the HIPPA Notice of Privacy Practices that was provided by this office, and understand its terms.

Signature: _____ **Date:** _____

Revised 11/29/17

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INITIAL VISIT HISTORY

Name_____ **BIRTHDATE**_____ **ID#**_____

CHIEF COMPLAINT: _____

_____

HISTORY OF PRESENT ILLNESS

How and when did symptoms begin? _____

_____

_____

On a scale of 0-10 (*with 10 being the worst),* rate the pain you currently experience in your:
____Neck ____Mid back ____Low back ____Other_____

Check all that apply:

When is your pain the worst? ____Morning ____Afternoon ____Night

_____

What does your pain interfere with? ____Work ____Sleep ____Daily Routine ____Recreation

_____

What activities aggravate your pain? ____Sitting ____Standing ____Walking ____Bending
____Lying down ____Driving ____Lifting

_____

Are you experiencing any? ____Numbness____Tingling ____Radiating pain ____Burning
____Aching ____Tenderness ____Edema ____Muscle spasms

_____

Have you seen another doctor for this condition? Yes / No
If so, who and when? _____
Does anything help to relieve your symptoms? Yes / No
If so, what?_____
Secondary complaints (Any other complaints): _____

_____

Do you smoke? _____ **How much a day?** _____ **Drink alcohol?**_____ **How often?**_____
Do you use any other substances? _____ **If so, what and how often?** _____
Special Diet? _____
Exercise? _____
Occupation/Recreation?_____

Any and all information that is recorded on this page is true to my knowledge. I have discussed any issues with Dr. Tucker or his staff and have no contraindications to chiropractic care.

_____ _____
Patient **C.A.**

_____ _____
Chiropractor **Date**