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

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

Date of Birth: _____ **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: Home or Cell **May we leave a message for you? Y/N**

Mother's Name: _____ **Date of Birth:** _____
Social Security #: _____ **Phone #:** _____
Employer: _____ **Work Phone #:** _____
Employer's Address: _____
City: _____ **State:** _____ **Zip:** _____

Father's Name: _____ **Date of Birth:** _____
Social Security #: _____ **Phone #:** _____
Employer: _____ **Work Phone #:** _____
Employer's Address: _____
City: _____ **State:** _____ **Zip:** _____

In case of emergency, who should we contact? _____
Relationship: _____ **Phone #:** _____

Reason for this visit: _____
Who referred you to our office? _____
Have you received chiropractic treatment before? Yes / No When? _____
Reason? _____
Date of last spinal x-ray: _____ **Date of last physical exam:** _____
Name of your Medical Physician: _____
Are you presently under the care of your Medical Physician? Yes / No
Reason: _____
Drug Allergies: _____
Adverse reaction to allergy: _____
Please list any medications or vitamins you take: _____
_____
_____
_____

Please list any severe illnesses and dates: _____
_____
_____
_____

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

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Patient's Name: _____ **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

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

____ Strokes	____ Liver Disease
____ High Blood Pressure	____ Anemia
____ Low Blood Pressure	____ Kidney Disease
____ Heart Disease	____ Tuberculosis
____ Cancer	____ Diabetes

Please explain anything checked: _____
_____
_____
_____
_____
_____

Would you like us to share your medical or financial information with anyone? (Check all that apply) ___Medical ___Financial With 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/payment 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 my minor child, 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.

Parent/Guardian's Signature: _____ **Date:** _____

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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**