MINORIK CHIROPRACTIC CENTER
2620 W Market Street
Fairlawn, OH 44313
(330) 869-6566

Patient ID #_____

Date _____

CONFIDENTIAL PATIENT INFORMATION

Social Security # _____

Name _____ **Home 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 _____

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

Date of Last Physical Examination _____ Family Physician _____

Medications _____ ☐ None

Allergies _____ ☐ None

Tobacco Use ☐ Yes ☐ No Frequency _____

Have you ever suffered from:

	Yes	No		Yes	No
1. Dizziness	☐	☐	8. Asthma	☐	☐
2. Backaches	☐	☐	9. Neuritis	☐	☐
3. Heart Trouble	☐	☐	10. Digestive Disorders	☐	☐
4. Diabetes	☐	☐	11. Nervousness	☐	☐
5. Tuberculosis	☐	☐	12. Sinus Trouble	☐	☐
6. Arthritis	☐	☐	13. Anemia	☐	☐
7. Headaches	☐	☐	14. Cancer	☐	☐

Reason for 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 _____

Remarks and additional information _____

_____

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

Name of Person Responsible for Payment _____

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

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that MINORIK CHIROPRACTIC CENTER 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 MINORIK CHIROPRACTIC CENTER 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 _____ Date _____

IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of the Accident _____ Time _____ AM / PM Location _____

How did Accident Occur? ☐ Auto Collision ☐ On the job Injury ☐ Other _____

If On-the-job Injury, how did it happen? _____

_____

_____

Did you report the injury to you foreman or employer? ☐ Yes ☐ No Your Job Title/Duties? _____

Did you tell them you were coming to our office? ☐ Yes ☐ No _____

If auto accident, were you: ☐ Driver ☐ Passenger ☐ Pedestrian _____

If auto collision, were you struck from: ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Parked ☐ Other _____

Did your car strike the other(s) involved? ☐ Yes ☐ No ☐ Undetermined

OR did the other car strike yours? ☐ Yes ☐ No ☐ Undetermined

As a result of the accident, were traffic citations issued to you? ☐ Yes ☐ No

Or to the driver of the other car? ☐ Yes ☐ No

Or to the driver of your car? ☐ Yes ☐ No ☐ Not Applicable

List the extent of the injuries as you know them _____

_____

_____

Did you require post-accident hospitalization? ☐ Yes ☐ No

Check Symptoms you have noticed since the accident:

☐ Headache
☐ Neck Pain
☐ Neck Stiffness
☐ Problems Sleeping
☐ Back Pain
☐ Nervousness
☐ Tension
☐ Irritability
☐ Chest Pain

☐ Dizziness
☐ Head Seems Too Heavy
☐ Pins & Needles in Arms
☐ Pins & Needles in Legs
☐ Numbness in Fingers
☐ Numbness in Toes
☐ Shortness of Breath
☐ Fatigue
☐ Depression

☐ Light Bothers Eyes
☐ Loss of Memory
☐ Ears Ring
☐ Face Flushed
☐ Buzzing in Ears
☐ Loss of Balance
☐ Fainting
☐ Loss of Smell
☐ Loss of Taste

☐ Diarrhea
☐ Feet Cold
☐ Hands Cold
☐ Stomach Upset
☐ Constipation
☐ Cold Sweats
☐ Fever
☐ _____
☐ _____

Symptoms other than above _____

_____

Have you lost any days of work? ☐ Yes ☐ No Dates: _____

Insurance Companies Involved (Auto Accidents Only)

My Company _____

Company of person responsible for injuries _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ Yes ☐ No

Do you have an attorney that has advised you in this case? ☐ Yes ☐ No

Attorney's Name _____

Address _____ Phone _____

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