**Welcome to Saggau Chiropractic Clinic, Ltd.** #\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information**

First Middle Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date \_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sex:  F  M Marital Status:  S  M  W  D**

**Mark your race:** White Asian Black or African American

Native Hawaiian or other pacific islands American Indian Alaska Native other unknown

**Mark you ethnicity:** Not Hispanic or Latino  Hispanic or Latino  unknown

List your preferred language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-mail Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You will be sent a link to view your clinic information. You will need to set up an account if you choose to view that information.

Employer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse Birth date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person who referred you to our office \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

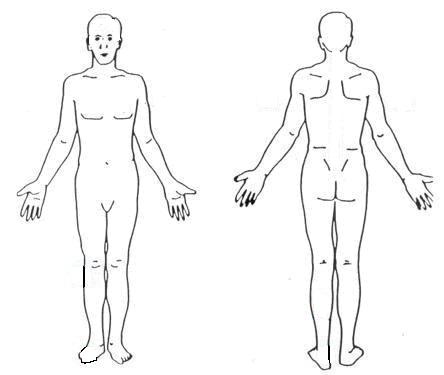
**Patient Condition**

Reason for Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling.

****Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Type of Pain: Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it interfere with: Work Sleep Daily Routine Recreation

Please mark activities or movements that are painful to perform:

Standing Sitting Walking Bending Lying Down

**Family History**

Father: Alive Deceased - Present health or cause of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother: Alive Deceased - Present health or cause of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings: Number alive\_\_\_\_\_\_\_\_\_ Present health\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number deceased\_\_\_\_ Cause of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Check illnesses which have occurred in any of your blood relatives: Diabetes Cancer

Bleeding tendency Kidney Disease Tuberculosis Heart Disease Stroke High Blood pressure Nervous Illness Allergy Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health History

Please mark any of the following that you have now or have experienced. All information is strictly confidential.

 Neck Stiff  Neck Pain  Depression  High Blood Pressure

 Headaches  Joint Swelling  Light Bothers Eyes  Stroke

 Fever  Sleeping Problems  Loss of Memory  Cancer

 Loss of Balance  Low Back Pain  Shoulder Pain  Painful urination

 Pain in Hands or Arms  Nervousness  Shortness of Breath  Diabetes

 Numbness in Hands or Arms  Tension  Asthma  Upset Stomach

 Pain Legs or Feet  Irritability  Allergies  Loss of Smell or Taste

 Numbness on Legs or Feet  Dizziness  Chest Pains  Diarrhea

 Fatigue  Pain Between Shoulders  Heart Attack  Constipation

Please mark any places of Pain, weakness or numbness

 Arms  Hips Neck Back  Hands  Legs  Shoulders  Feet

**Women:** Are you pregnant? \_\_\_\_\_\_\_ Nursing?\_\_\_\_\_\_\_\_\_ Number of Children?\_\_\_\_\_\_\_\_\_

Check conditions you have or have had in the past.

 AIDS/HIV  Diabetes  Kidney Disease  Prosthesis

 Anorexia  Emphysema  Liver Disease  Psychiatric Care

 Appendicitis  Epilepsy  Migraine Headaches  Stroke

 Arthritis  Gout  Multiple Sclerosis  Thyroid Problems

 Asthma  Heart Disease  Osteoporosis  Tumors

 Broken Bones  Hepatitis  Pacemaker  Venereal Disease

 Cancer  Hernia  Parkinson’s Disease  Polio

 Chemical Dependency  Herniated Disc  Pinched Nerve  High Cholesterol

Depression  TMJ

Check any uses and how often used  Caffeine \_\_\_\_\_\_ (cups per day?)

 Street Drugs \_\_\_\_\_\_\_\_(How often?)  Tobacco \_\_\_\_\_\_\_\_\_ (how often?)  Exercise \_\_\_\_\_\_\_\_(how often?)

Check if your work exposes you to  Stress Heavy Lifting Hazardous substances  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all surgeries and year performed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medications and/or vitamins you are currently taking\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list allergies to medications or substances\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of ins. Company) and assign directly to Saggau Chiropractic Clinic, Ltd. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all submissions. The above named clinic may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits.

Print name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_