Brett A. Short, D.C.
Eric Cooper, D.C.
Destiny Cooper, D.C.

Patient Information ___ **Date: ________**

Name____ Marital Status: ☐Married ☐Single ☐Divorce ☐Widowed

Address: _______________________________________ City: __________________________ State: ______ Zip: _______

Home Phone #: ________________________ Cell Phone:_________________________ Work Phone: ________________

Age: ____ Date of Birth: _______________ SS#: _____________________ Sex: M F Height: _______ Weight: _______

Email: ___________________ Student: Full-Time ___ Part-Time___ Name of School: ____________________________

Your Occupation: _____________________________ Employed by: ____

Your Spouse Name: ____ Spouse Date of Birth:__________________

Spouse's Employer: _______________________________________ Spouse's Work Phone: ___________________________

Name of person to contact in case of emergency: _________________________________ Phone: ___________________

Name of nearest relative not living with you: _____________________________________ Phone: ____________________

Who referred you to this office so we may thank them? ____

Referring Physician: ____

Is your visit due to an accident? Yes/ No ☐Auto ☐Work Date of Injury: ____________________________

Have you had Chiropractic in the past? Yes / No If yes, When?____________________________________

Doctor's Name: _______________________________________ Results: _____________________________________

Who is your Medical Doctor? ____ Last Visit: ______________

TREATMENT OF MINOR (must be signed by parent or legal guardian if patient is a minor under age 18). I hereby authorize Short Chiropractic Inc. and its assistants to administer chiropractic are as deemed necessary to my _______. (relationship)

____ __________________________

Signature of Parent/Guardian **Date**

Insurance Coverage Information

Primary Insurance Carrier: ____ Phone: _____________________

Policy Holder Name: ____________________________________ Policy Number _______________________________

Group Number ____ Relationship: ☐Self ☐Spouse ☐Child ☐Other

Insured Date of Birth: ______________ Insured Home Phone: ____________________ Insured Work: _______________

Secondary Insurance Carrier: ____ Phone : _______________________

Policy Holder Name: ____________________________________ Policy Number _______________________________

Group Number ____ Relationship: ☐Self ☐Spouse ☐Child ☐Other

Insured Date of Birth: ______________ Insured Home Phone: ____________________ Insured Work: _______________

Auto / Personal Injury: Do you have "Med Pay" on your Auto Policy: Yes / No Amount: $ _________________

Insurance Carrier Name: ____ Phone: __________________________

Adjuster: ____ Claim Number: ___________________________________

DESCRIBE MAJOR COMPLAINTS & SYMPTOMS: ____

____

____.

Where is your pain? How does it feel? Draw your pain using the following key.

KEY:

Stabbing / / /

Burning X X X

Pins O O O

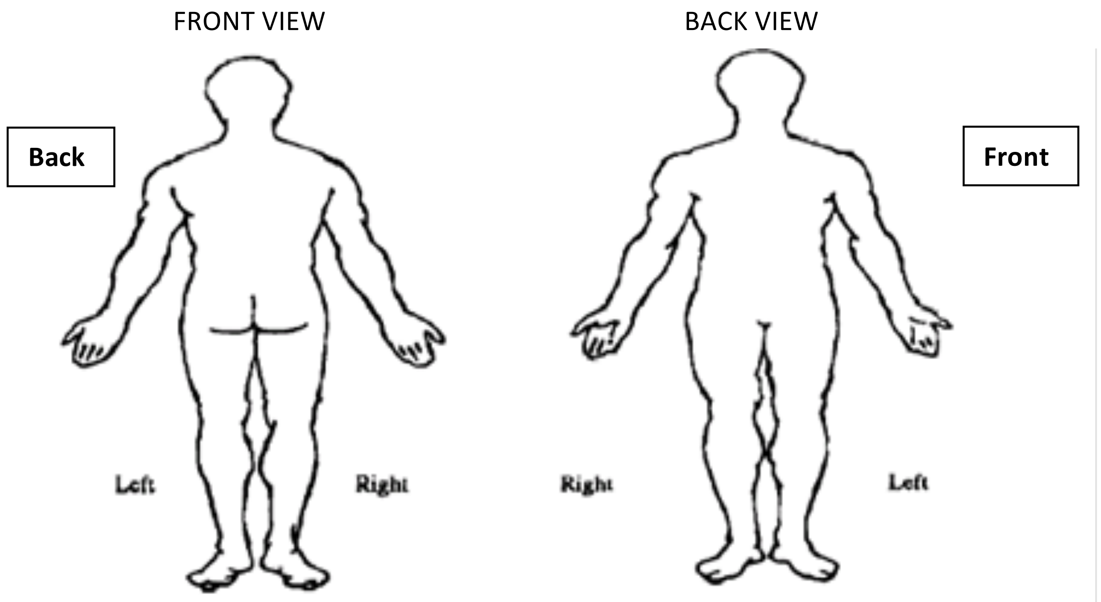
And Needles

Aching, ^ ^ ^

Throbbing

Numbness = = =

Other • • •



List any doctors or therapists that you have seen for this complaint:

1.____**Specialty**____________________

2. ____**Specialty**____________________

3. ____**Specialty**____________________

List any operations that you've had and approximate dates:

1. ____ **Date:** __________ **Dr:** ____________________

2. ____ **Date:** __________ **Dr:** ____________________

3. ____ **Date:** __________ **Dr:** ____________________

Are you allergic to any medication? ____ **Please list:** ____

____

Are you taking any medications? _____**Please list:** ____

____

Do you wear Orthotics (shoe inserts)? Yes / No **If yes, what type?** ______________________________

Please check the appropriate box for any of the following symptoms which you currently have.

GENERAL	Occasional	Frequent
Allergies	☐	☐
Convulsions	☐	☐
Dizziness or Fainting	☐	☐
Headache	☐	☐
Neuralgia	☐	☐
Numbness/sensation loss	☐	☐

MUSCLE & JOINT	Occasional	Frequent
Arthritis	☐	☐
Bursitis	☐	☐
Foot Trouble	☐	☐
Low back pain	☐	☐
Neck pain or stiffness	☐	☐
Pain between shoulders	☐	☐
Sciatica	☐	☐
Swollen Joints	☐	☐
Pain, numbness/ cramps	☐	☐
Shoulders	☐	☐
Arms	☐	☐
Elbows	☐	☐
Hands	☐	☐
Hips	☐	☐
Legs	☐	☐
Knees	☐	☐
Feet	☐	☐

GASTRO-INTESTINAL	Occasional	Frequent
Colon Trouble	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Difficult digestion	☐	☐
Distension of abdomen	☐	☐
Gallbladder Trouble	☐	☐
Hemorrhoids	☐	☐
Liver trouble	☐	☐
Pain of stomach	☐	☐
Difficult swallowing	☐	☐

EYES,EARS,NOSE,&THROAT	Occasional	Frequent
Asthma	☐	☐
Colds	☐	☐
Hearing loss	☐	☐
Earache	☐	☐
Ear Discharge	☐	☐
Ear noises	☐	☐
Eye pain	☐	☐
Nasal obstruction	☐	☐
Nosebleeds	☐	☐
Sinus infection	☐	☐
Blurred vision	☐	☐
Loss of vision	☐	☐

CARDIO-VASCULAR	Occasional	Frequent
Hardening of arteries	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Pain over heart	☐	☐
Poor circulation	☐	☐
Rapid heartbeat	☐	☐
Slow heartbeat	☐	☐
Swelling of ankles	☐	☐
Slurred speech	☐	☐
Weakness/Clumsiness	☐	☐

RESPIRATORY	Occasional	Frequent
Chest pain	☐	☐
Chronic Cough	☐	☐
Difficult breathing	☐	☐
Spitting up blood	☐	☐
Spitting up phlegm	☐	☐
Wheezing	☐	☐

GENITO-URINARY	Occasional	Frequent
Bed-wetting	☐	☐
Blood in urine	☐	☐
Frequent urination	☐	☐
Inability to control kidneys	☐	☐
Kidney infection or stones	☐	☐
Painful irritation	☐	☐
Prostate trouble	☐	☐
Pus in urine	☐	☐

SKIN	Occasional	Frequent
Bruise	☐	☐
Dryness	☐	☐
Skin eruptions (rash)	☐	☐
Varicose veins	☐	☐

FOR WOMEN ONLY	Occasional	Frequent
Congested breasts	☐	☐
Cramps or backache	☐	☐
Hot flashes	☐	☐
Irregular cycle	☐	☐
Lumps in breast	☐	☐
Menopausal symptoms	☐	☐
Painful menstruation	☐	☐
Vaginal Discharge	☐	☐

Pregnant ☐yes ☐no

Date of Last Period___________

Previous Miscarriages? ☐yes ☐no

	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Exercise	☐	☐	☐	☐

Relevant medical history: **(Please circle the conditions you have or had previously)**

Aids/HIV	Diabetes	Heart problems	Rheumatic Fever
Alcoholism	Digestion problems	Hepatitis	Scarlet Fever
Arthritis	Dizziness	High blood pressure	Sciatica
Asthma	Eczema	Measles	Scoliosis
Anemia	Emphysema	Multiple Sclerosis	Sinus trouble
Appendicitis	Epilepsy	Mumps	Stroke
Arteriosclerosis	Fibromyalgia	Muscular Dystrophy	Tuberculosis
Back pain or spasm	Foot Problems	Neck pain or spasms	Typhoid Fever
Cancer	Goiter	Numbness	Ulcers
Chicken Pox	Gout	Pacemaker	Venereal disease
Concussion	Hand or wrist pain	Pneumonia	
Convulsion	Headaches	Polio	

Does anyone in your family have a similar health related problem? Yes / No

Who: ___________________________ What condition:_______________________________

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement. I hereby authorize and direct my medical benefits to be paid to Short Chiropractic Inc and agree that I am financially responsible for non-covered services or items. I hereby give permission to Short Chiropractic Inc. to administer treatment and perform such general procedures as the doctor may deem necessary in the diagnosis and/or treatment for my condition.

Patient's Signature: ____ Date________________

Parent or Guardian: ____

Signature: ____ Date _______________