PLEASE BRING THESE ITEMS TO YOUR VISIT

AUTO INSURANCE

- Insurance Company (Auto or Workman's Comp)
  – Name, Address, Phone Number
- Auto Insurance Policy Card
- PIP Policy Declaration Page
- Adjuster's Name and Phone Number
- Insurance Claim Number

HEALTH INSURANCE

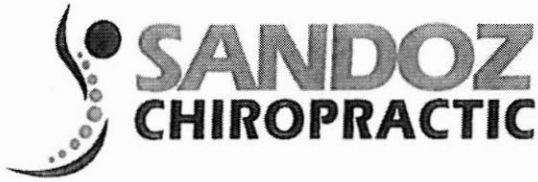
- Health Insurance Card(s)

ATTORNEY

- Attorney's Name, address, & phone number (if applicable)
- Letter of Protection

OTHER ITEMS

- Driver's License
- Police Report
- PIP Application of Benefits form (PLEASE OBTAIN FROM ADJUSTER)



Sandoz Chiropractic Center
2057 Briggs Road Suite 204
Mount Laurel, NJ 08054
PH: 856-206-9560 Fax: 856-206-9701
www.sandozchiropractic.com
frontdesk@sandozchiropractic.com

Welcome To Sandoz Chiropractic Center
CONFIDENTIAL PATIENT INFORMATION FORM – PLEASE PRINT

First Name: ____ Middle: ____ Last: ____

Preferred Name: ____ Maiden Name: ____

Race (choose one): [Asian] [African American] [Caucasian] [Hispanic] [Native American] [Other]

Ethnicity (choose one): [Non-Hispanic] [Hispanic] [Withheld]

Address: ____ Postal Code: ____

City ____ State: ____ E-mail address: ____

Appointment reminder preference: [Cell Phone Call] [Home Phone Call] [Text Message] [E-mail]

(Circle more than one above if you would prefer that)

Home Phone ____ Work Phone ____ Cell Phone ____

Cell phone carrier (for text messages) [AT&T] [Verizon] [Sprint] [Virgin] Other ____

Date of Birth / / Social Security Number - -

Gender: [Male] [Female] Height: ____ ft ____ in Weight: ____ lbs.

Married Single Divorced Widow(er) Number of Children ____ Pregnant: ____ Due Date: ____

Employer ____ Occupation ____

Emergency Contact: ____ Contact Phone # ____

Whom may we thank for referring you? ____

Primary Care Doctor: ____ Phone: ____

Chiropractors you have seen before:

Name ____ City ____ State ____ When ____

List all accidents or injuries:

Type ____ When ____ Hospitalized? ____

List all surgeries:

Type ____ When ____

List medications and/or vitamins and supplements you are taking

Name ____ For ____ How long ____

Name ____ For ____ How long ____

Use back of sheet for any additional space needed.

PAIN DRAWING

Name: ______________________ Date: ______________

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark the area of radiating pain, and include all affected areas. You may draw on the face as well.

Pain Symbols:

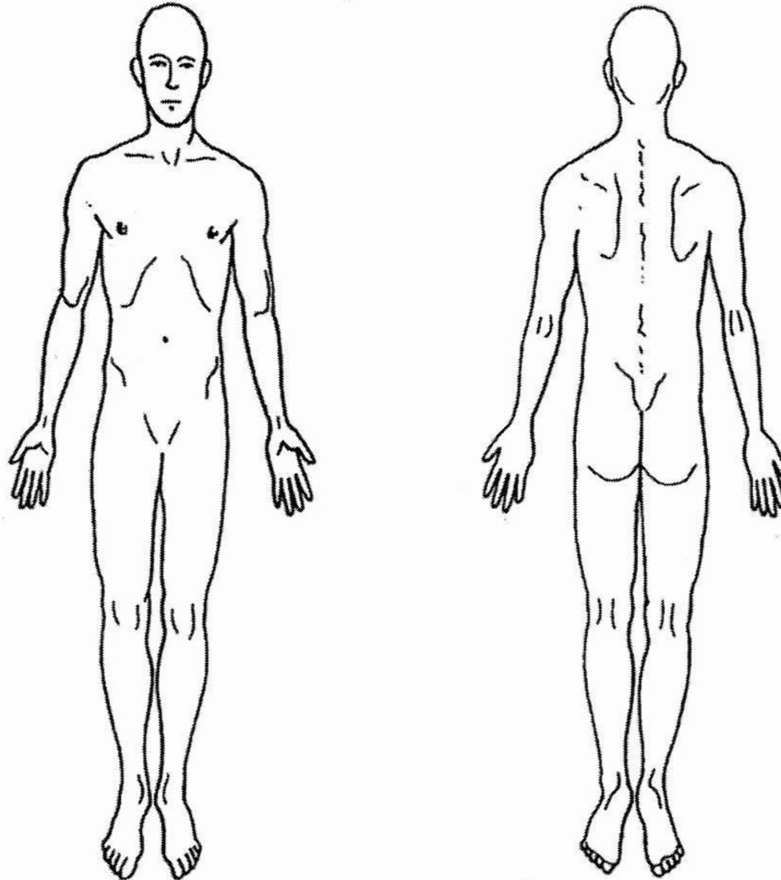
Numbness

Pins & Needles
0000000

Burning Pain
XXXXXXXX

Stabbing Pain
///////////

Aching Pain
((((((((



Chief Complaint: ______________________

Patient Explanation of Incident: ______________________

Date of Onset: __________ Did symptoms appear gradually or suddenly? __________
On the Job: ____ Yes ____ No Days off work: __________
Auto Accident: ____ Yes ____ No Days off work: __________

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Patient Name: ____________________ Date: ____________

Below are listed common symptoms which may suggest the presence of an ailment involving a particular body system. If you ever had a listed symptom in the past, please check that symptom in the left hand column. If you are presently troubled by a particular symptom, check that symptom in the right hand column.

Past	Musculoskeletal	Present
[ ]	Neck pain	[ ]
[ ]	Shoulder pain	[ ]
[ ]	Pain in upper arm or elbow	[ ]
[ ]	Hand pain	[ ]
[ ]	Upper back pain	[ ]
[ ]	Low back pain	[ ]
[ ]	Pain in upper leg or hip	[ ]
[ ]	Pain in lower leg or knee	[ ]
[ ]	Pain in ankle or foot	[ ]
[ ]	Jaw pain	[ ]
[ ]	Swelling in joints (list joints) ____	[ ]
[ ]	Stiffness of joints (list joints) ____	[ ]

Past	Nervous System	Present
[ ]	Depression	[ ]
[ ]	Insomnia	[ ]
[ ]	Bed wetting	[ ]
[ ]	Fainting	[ ]
[ ]	Convulsions	[ ]
[ ]	Dizziness	[ ]
[ ]	Headache	[ ]
[ ]	Muscular incoordination	[ ]
[ ]	Hearing loss	[ ]
[ ]	Tinnitus (ear noises)	[ ]
[ ]	Ear pain	[ ]
[ ]	Impaired vision	[ ]
[ ]	Eye pain	[ ]
[ ]	Paralysis	[ ]

Past	Cardiovascular	Present
[ ]	Rapid heartbeat	[ ]
[ ]	Chest pains	[ ]

Past	Endocrine	Present
[ ]	Loss of appetite	[ ]
[ ]	Abnormal weight gain	[ ]
[ ]	Abnormal weight loss	[ ]

Past	Respiratory	Present
[ ]	Shortness of breath	[ ]
[ ]	Chronic pain	[ ]
[ ]	Chronic cough	[ ]
[ ]	Chronic sinusitis	[ ]

Past	Gynecologic	Present
[ ]	Pain during menstruation	[ ]
[ ]	Irregular menstrual flow	[ ]
[ ]	Spotting	[ ]
[ ]	Menopausal symptoms	[ ]

Past	Genito-Urinary	Present
[ ]	Painful urination	[ ]
[ ]	Loss of bladder control	[ ]
[ ]	Frequent urination	[ ]
[ ]	Urethral discharge	[ ]

Past	GI Tract	Present
[ ]	Abdominal pain	[ ]
[ ]	Difficult swallowing	[ ]
[ ]	Heartburn/indigestion	[ ]
[ ]	Constipation	[ ]
[ ]	Diarrhea	[ ]

Past	Skin	Present
[ ]	Rash	[ ]
[ ]	Dermatitis or eczema	[ ]
[ ]	Persistent itching	[ ]

Please check any of the following that apply to you.

- [ ] Tobacco
- [ ] Alcohol, Qty/Frequency ____
- [ ] Tranquilizers/Sedatives
- [ ] Laxatives
- [ ] Coffee, cups/day ____
- [ ] Regular soda, cans/day ____
- [ ] Diet soda, cans/day ____
- [ ] Water ____

Family History: Listed below are common diseases and disorders. Please indicate whether you have a Parent, Sibling, and/or Grandparent who have had a particular disorder in the past or are presently troubled by a listed disorder.

Past	Condition	Present
[ ]		[ ]
[ ]	Heart disease	[ ]
[ ]	High blood pressure	[ ]
[ ]	Angina	[ ]
[ ]	Heart attack	[ ]
[ ]	Stroke	[ ]
[ ]	Asthma	[ ]
[ ]	Gallbladder	[ ]
[ ]	Cancer	[ ]
[ ]		[ ]

Past	Condition	Present
[ ]	Emphysema	[ ]
[ ]	Arthritis	[ ]
[ ]	Drug or alcohol dependency	[ ]
[ ]	Diabetes	[ ]
[ ]	Ulcer	[ ]
[ ]	Kidney stones	[ ]
[ ]		[ ]
[ ]	Other ____	[ ]
[ ]	Other ____	[ ]
[ ]	Other ____	[ ]