

## ***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**

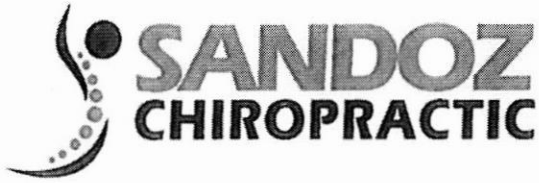
- Health Insurance Card(s)

### **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](http://www.sandozchiropractic.com)  
[frontdesk@sandozchiropractic.com](mailto: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.

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[frontdesk@sandozchiropractic.com](mailto:frontdesk@sandozchiropractic.com) - [www.sandozchiropractic.com](http://www.sandozchiropractic.com)

# 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:

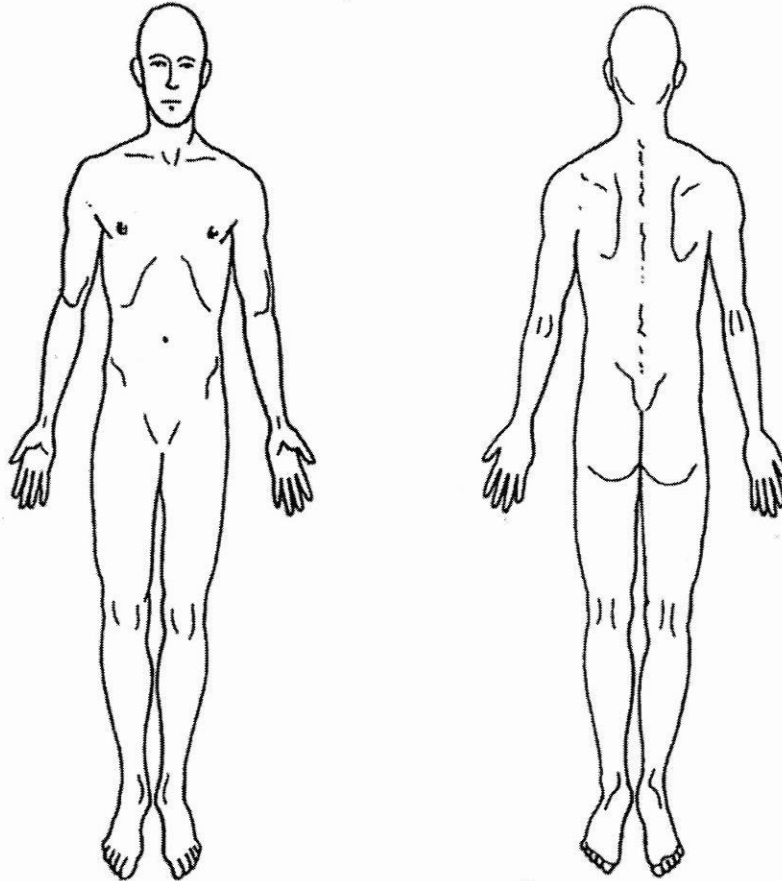
Numbness  
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Pins & Needles  
o o o o o o o o

Burning Pain  
x x x x x x x x

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: \_\_\_\_\_

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	[ ]