



patient form

7117 Geyer Springs Road ■ Little Rock, AR 72209 ■ 501-568-6612
www.geyerspringschiropractic.com

PATIENT INFORMATION

Full Name _____ Birth Date _____ Gender: M F
Address _____ City _____ State _____ Zip _____
Home Phone: _____ Work Phone: _____ SS# _____ - _____ - _____
Cell Phone: _____ Email Address: _____
Marital Status: S M W D Sep / Spouse Name _____ Birth Date _____
Are You A Student? Yes No / Full-Time Part-Time
Your Employer _____ Your Occupation _____
Employer Address _____ City _____ State _____ Zip _____
Spouse's Employer _____ Spouse's Occupation _____
Children at Home: Names & Ages _____

*****HEALTH INSURANCE - Please allow our staff to photocopy your current health insurance card(s).*****
Insurance Company _____ Phone # _____
ID# _____ Group # _____

Who may we thank for referring you to our office? _____

- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
I give this office the right to use my name for any in-office publications.
Authorization may be denied or retracted by notifying the office manager.
I acknowledge having the right to review and obtain a copy of the Notice of Privacy Practices of this office. (Once information is disclosed, it may not be protected by law.)
I authorize payment of medical benefits to this office.
I understand that I am responsible for any charges at Geyer Springs Chiropractic and billing of insurance is done as a courtesy, and any balance not collected by insurance is my responsibility.
I understand that Geyer Springs Chiropractic may not be a participating provider with my health insurance plan; therefore I may be financially liable for any uncovered services that are provided to me in this office.
In the event your account is turned over to collections, additional fees (attorney's fees, court costs, etc.) will be added to your balance.
I authorize release of my medical records, for the purposes of diagnosis and treatment, to the above-mentioned physician/facility.

Patient's Signature _____ Date _____

Spouse's / Guardian's Signature _____ Date _____

(Authorization expires 3 years from date above.)

History of Present Injury

Please list below the complaint(s) you have in the order of importance; also the length of time you have had these complaint(s).

- 1. _____ How Long? _____
- 2. _____ How Long? _____
- 3. _____ How Long? _____
- 4. _____ How Long? _____

Is your condition(s) related to an accident? YES NO
 Date of accident: _____ Type of Accident: Auto Work Related Other _____

What words best describe your present condition(s)? (ex. ache, burn) _____
 Circle the number that matches your level of pain at its worst (0=no pain, 10=most severe)
 0 1 2 3 4 5 6 7 8 9 10

When is your condition most severe? _____

When is your condition least severe? _____

What makes your condition feel worse? _____

What makes your condition feel better? _____

What activities are difficult because of your condition(s)? _____

Have you seen any other health care provider for your present condition? YES NO

Who? _____
 Current Medications _____

Are you or could you be pregnant? YES NO

Are you experiencing or do you have any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> A sore that won't heal | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Persistent cough/hoarseness |
| <input type="checkbox"/> Any bleeding/discharge | <input type="checkbox"/> Lump/thickening anywhere | <input type="checkbox"/> Wart/mole changes |
| <input type="checkbox"/> Bladder/bowel problems | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Weight loss without trying |
| | | <input type="checkbox"/> None of the above |

Review of Systems

In addition to the symptom(s)/dysfunction(s) listed above, are you experiencing any of the following?

Neuromusculoskeletal System

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Facial drooping | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Atrophy | <input type="checkbox"/> Headache | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Sensory changes |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Joint deformity | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Joint locking | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Popping noises | <input type="checkbox"/> Twitches |
| <input type="checkbox"/> Extremity deformity | <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Psychiatric disorders | <input type="checkbox"/> Vision Trouble |
| | | | <input type="checkbox"/> None of the above |

Cardiovascular System

- | | | | |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Pin stroke |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Known vascular disease | <input type="checkbox"/> Previous stroke |
| <input type="checkbox"/> Carotid blockage | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Changes in skin color | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Varicose veins |
| | | | <input type="checkbox"/> None of the above |

Past History

List any surgeries you have had (including appendix, tonsils, wisdom teeth).

- 1. _____ Date _____ 3. _____ Date _____
- 2. _____ Date _____ 4. _____ Date _____

Have you ever been hospitalized for anything in addition to surgeries? YES NO

If so, when and for what reason? _____

Have you ever been diagnosed as having a particular condition? (diabetes, heart trouble, cancer)

NO YES _____

Do you have any surgically implanted devices? (pacemaker, stent, defibrillator, etc.) NO YES _____

