Beeson Chiropractic Center

P. O. Box 25191 • Prescott Valley, AZ 86312 • 928.772.8638

Patient Information

Today's Date_______________

Patient Name:______________________________

Address:______________________________

City:________________ State_____ Zip__________

E-Mail______________________________

Sex: ☐M ☐F Birthdate________________ Age_____

Marital Status_________

Ages of children living at home ____________________

Patient Employer/School______________________

Occupation______________________________

Number of years in this occupation ________________

Spouse's Name______________________________

Spouse's Date of Birth__________________________

Spouse's Employer____________________________

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐Phone Directory ☐Sign ☐Internet

☐Referred by Patient (Name)____________________

☐Other source____________________________

Phone Numbers

Home ( )____________________________

Cell ( )____________________________

Work ( )____________________________

Best number to reach you: ☐Home ☐Cell ☐Work

IN CASE OF EMERGENCY, CONTACT:

Name__________________Relationship_________

Home ( )_____________Cell ( )__________

Account Information

Who is responsible for this account?_______________

Relationship to Patient________________________

☐Cash ☐Insurance ☐Medicare ☐ChiroHealth

Primary Insurance Co. ________________________

Secondary Insurance Co. ______________________

I certify that I and/or my dependent has insurance coverage as stated above and assign payment of benefits directly to Dr. Beeson. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. Dr. Beeson may use my health information and may disclose such information to the above-named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my treatment is completed or 3 years from date signed below.

Printed Name of Patient________________________

____

Signature of Patient or Guardian Date

Previous Treatment Info

What treatment have you already received for your condition? ☐None ☐Medications ☐Surgery ☐Physical Therapy ☐Chiropractic ☐Other

Date of Last: (month and year):

Physical Exam_____________

Spinal X-ray___________ Blood Test__________

Spinal Exam___________ Chest Xray__________

MRI, CT Scan, Bone Scan________________

Dental X-ray_____________

Accident Information

Is condition due to an accident? ☐Yes ☐No Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other

Accident Date______________________________

To whom have you made a report of your accident? ☐Auto Insurance ☐Employer ☐Work Comp ☐Other

Do you have a police report? ☐Yes ☐No Attorney's Name__________________________________

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Patient Condition

Please list all complaints about which you wish to speak to the Dr.

Complaint #1 ____

What do you believe caused this symptom? ______________________________

When did this symptom appear?______________________ Getting worse?____ Better?____ Same?____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain) _______

Type of Pain (circle all that apply): Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Constant Intermittant Other

When does the symptom appear? mornings sleeping rising from a chair bending sitting standing walking Other

What makes the symptom better?______________________________________

What makes the symptom worse?______________________________________

Does it interfere with: Work Daily Routine Recreation Sleep Other

What percent does it interfere with your activities of daily living? _______%

Complaint #2 ____

What do you believe caused this symptom? ______________________________

When did this symptom appear?______________________ Getting worse?____ Better?____ Same?____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain) _______

Type of Pain (circle all that apply): Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Constant Intermittant Other

When does the symptom appear? mornings sleeping rising from a chair bending sitting standing walking Other

What makes the symptom better?______________________________________

What makes the symptom worse?______________________________________

Does it interfere with: Work Daily Routine Recreation Sleep Other

What percent does it interfere with your activities of daily living? _______%

Complaint #3 ____

What do you believe caused this symptom? ______________________________

When did this symptom appear?______________________ Getting worse?____ Better?____ Same?____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain) _______

Type of Pain (circle all that apply): Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Constant Intermittant Other

When does the symptom appear? mornings sleeping rising from a chair bending sitting standing walking Other

What makes the symptom better?______________________________________

What makes the symptom worse?______________________________________

Does it interfere with: Work Daily Routine Recreation Sleep Other

What percent does it interfere with your activities of daily living? _______%

If you have additional complaints, please ask at the front desk for an additional page.

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Health History

Use check mark to indicate if you have had any of the following:

Addiction	_____	Depression	_____	Hypertension	_____	Poor Posture	_____
AIDS/HIV	_____	Diabetes	_____	High Cholesterol	_____	Prostate Problem	_____
Alcoholism	_____	Dizziness	_____	Kidney Disease	_____	Prosthesis	_____
Allergies	_____	Emphysema	_____	Liver Disease	_____	Rheum. Arthritis	_____
Anemia	_____	Epilepsy	_____	Measles	_____	Rheumatic Fever	_____
Anorexia	_____	Fibromyalgia	_____	Migraines	_____	Scarlet Fever	_____
Appendicitis	_____	Fractures	_____	Menstrual Probl.	_____	Scoliosis	_____
Arthritis	_____	Gall Bladder	_____	Miscarriage	_____	Shingles	_____
Asthma	_____	Glaucoma	_____	Mononucleosis	_____	Stroke	_____
Blood Pressure	_____	Goiter	_____	Multiple Sclerosis	_____	Suicide Attempt	_____
Breast Lump	_____	Gonorrhea	_____	Mumps	_____	Thyroid Problems	_____
Bronchitis	_____	Gout	_____	Numbness	_____	Tonsillitis	_____
Bulimia	_____	Headaches	_____	Osteoporosis	_____	Tuberculosis	_____
Cancer	_____	Heart Disease	_____	Pacemaker	_____	Typhoid Fever	_____
Cataracts	_____	Hepatitis	_____	Parkinson's	_____	Ulcers	_____
Chronic Fatigue	_____	Hernia	_____	Pinched Nerve	_____	Vaginal Infections	_____
Constipation	_____	Herniated Disk	_____	Pneumonia	_____	Whooping Cough	_____
Chicken Pox	_____	Herpes	_____	Polio	_____	C-Section (year)____________	

Exercise Frequency

- ☐ None
- ☐ Infrequent
- ☐ ____ per week
- ☐ Daily

Exercise Intensity

- ☐ Light
- ☐ Moderate
- ☐ Intense

Habits

- ☐ Smoking ____Packs per day
- ☐ Alcohol ____Drinks per day
- ☐ Coffee/Caffeine Drinks ___cups per day
- ☐ Stress (reason)____________________

_____ oz. of water do you drink per day

Work Activity

What % of your day is spent:

_____Sitting
_____Standing
_____Light Labor
_____Heavy Labor
_____Computer

Injuries and Surgeries you have had: Provide approx. date and description

Falls____

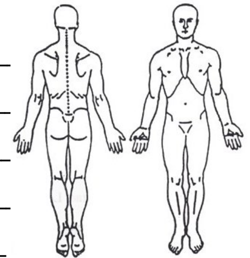
Head Injuries______________________________________

Broken Bones_______________________________________

Dislocations_______________________________________

Surgeries____

Women: Are you pregnant? Yes No Due Date:______________________



Mark areas of pain as indicated on page 2.

Family History

Mark any known conditions in your family.
(M - Mother, F - Father, GM - GrandMother, GF - GrandFather)

____Arthritis ____Asthma ____Back Pain ____Cancer ____Depression ____Diabetes ____Epilepsy,
____Genetic Spinal Condition ____High Blood Pressure ____Heart Problems ____Multiple Sclerosis
____Neurological Problems ____Parkinson's ____Polio ____Prostate Problems ____Stroke/Heart Attack
Other: ____

____

I certify that information provided to this office is up to date and correct to the best of my knowledge.
Child Release: I am the authorized parent or guardian of this child and I authorize this office to treat my child.

Patient Signature:________________________________Date__________________