Lardi Chiropractic Ltd

495 E. First Street, Coal City, IL 60416
815.634.3750

Patient Information

Name _____ Sex ☐ M ☐ F Birthdate _____
last first middle initial

Address _____
street city state zip

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation_____

Home Phone _____ Cell Phone _____

Who may we thank for referring you? _____

Spouse Information

Name _____

Birthdate _____ Employer _____

Emergency Contact

Name _____ Relationship _____
last first middle initial

Home Phone _____ Cell Phone _____

Insurance Information

Is your pain related to an ☐ Auto-accident ☐ Work Injury ☐ Neither

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Company _____

Group Number _____

Insured's Name _____

Birthdate _____

Relationship to Patient _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Insurance Company _____

Group Number _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Lardi Chiropractic LTD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand the above and guarantee this form was completed correctly to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes to the information I have provided.

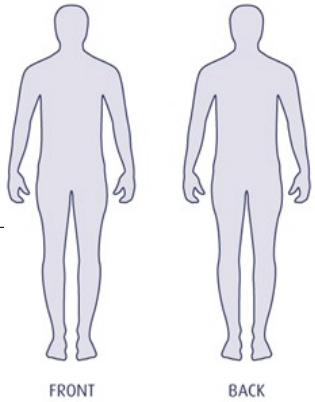
_____ Date _____
Responsible Party Signature

Relationship to Patient _____

Patient Condition

Reason for visit _____ When did your symptoms appear?_____

Circle on the picture where you experience pain, numbness or tingling.



Rate the serverity of your pain on a scale from 1 (least pain) to 10 (severe pain). _____

Type of pain (check all that apply) ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching

☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other: _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with (check all that apply) ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform (check all that apply) ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Health History

What treatment have you already received for this condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____

Name of other doctor(s) who have treated you for your condition _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Migraine ☐ Yes ☐ No	Rheumatoid Arthritis ☐ Yes ☐ No
Alcoholism ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No
Anorexia/Bulimia ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tumors/Growths ☐ Yes ☐ No
Bleeding Disorder ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Parkinson's Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Vaginal Infections ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Herniated Disc ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	High Bld Pressure ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Whooping Cough ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	Other
Chicken Pox ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No	Prosthesis ☐ Yes ☐ No	_____
Diabetes ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	_____
	Measles ☐ Yes ☐ No		

Exercise

☐ None
☐ Moderate
☐ Daily
☐ Heavy

Work Activity

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

Habits

☐ Smoking — Packs per day _____
☐ Alcohol — Drinks per week _____
☐ Coffee/Caffeine Drinks — Cups per day _____
☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No if so, Due date: _____ Are you breast feeding? ☐ Yes ☐ No

Injuries/Surgeries you have had

description	date
_____	_____
_____	_____
_____	_____

Medications

_____
_____

Allergies

_____
_____

Vitamins/Herbs/Minerals

_____
_____