BOURQUE
chiropractic clinic

PATIENT INFORMATION

Date: ____________ SS #: ____________________

Patient Title:(Circle One) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

Full Name: ______________________________

Nickname/Preferred Name: ____________________

Address: ______________________________

City: ______________________________

State: ______________ Zip: ______________

E-mail: ______________________________

Birthdate: __________ Age: ______ Sex: ☐ M ☐ F

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

Occupation: ______________________________

Employer/School: ______________________________

Spouse's Name: ______________________________

Spouse's Employer: ______________________________

PHONE NUMBERS

Cell Phone: ______________________________

Home Phone: ______________________________

Work Phone: ______________________________

Best time and place to reach you: ______________________________

INSURANCE INFORMATION

Who is responsible for this account? ____________________

Relationship to Patient: ____________________

Insurance Co: ____________________

Group #: ____________ ID#: ____________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name: ____________________

Birthdate: ____________ SS#: ____________

Relationship to Patient: ____________________

Insurance Co: ____________________

Group #: ____________ ID#: ____________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________ and assign directly to Dr. Bourque 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 authorize the use of my signature on all insurance submissions.

The above-named doctor(s) may use my health care information and may disclose such information to the above-named Insurance Company(ies) 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 current treatment plan is completed or one year from the date signed below.

____

Signature of Patient, Parent, Guardian or Personal Representative

____

Please print name of Patient, Parent, Guardian or Personal Rep.

______________ ______________

Date Relationship to Patient

Race: ☐ White ☐ Black/African American ☐ Hispanic ☐ American Indian/Alaskan Native ☐ Asian ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Native Hawaiian/ Pacific Island ☐ Samoan ☐ Guamanian/Chamorro ☐ Other__________ ☐ I choose not to specify

Multi-Racial: ☐ Yes ☐ No ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I choose not to specify

Preferred Language: ☐ English ☐ Spanish ☐ American Sign Language ☐ Chinese ☐ French ☐ German ☐ Vietnamese ☐ Italian ☐ Korean ☐ Russian ☐ Polish ☐ Arabic ☐ Portuguese ☐ Greek ☐ Hindi ☐ Persian ☐ Urdu ☐ Armenian ☐ Japanese ☐ Gujarati ☐ French Creole ☐ I choose not to specify

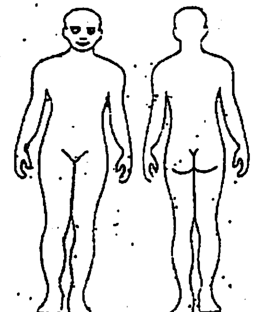
PATIENT CONDITION

Reason for visit: ______________________________

When did your symptoms appear? ______________________________

Is this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Cramps ☐ Tingling ☐ Stiffness ☐ Swelling ☐ Other

Does it interfere with: ☐ Work ☐ Sleep ☐ Recreation ☐ Daily Routine

Activities that are painful to perform: ☐ 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 ______

Other doctor(s) who have treated this condition for you: ______

Date of Last: Physical Exam ______ Spinal X-Ray______ Spinal Exam ______

Chest X-Ray ______ MRI/CT-Scan/Bone Scan______

Please circle "Yes" or "No" if you have had any of the following:

Condition			Condition			Condition			Condition		
AIDS/HIV	Yes	No	Diabetes	Yes	No	Liver Disease	Yes	No	Rheumatoid Arthritis	Yes	No
Alcoholism	Yes	No	Emphysema	Yes	No	Measles	Yes	No	Rheumatic Fever	Yes	No
Allergy Shots	Yes	No	Epilepsy	Yes	No	Migraines	Yes	No	Scarlet Fever	Yes	No
Anemia	Yes	No	Fractures	Yes	No	Miscarriage	Yes	No	STDs	Yes	No
Anorexia	Yes	No	Glaucoma	Yes	No	Mononucleosis	Yes	No	Stroke	Yes	No
Appendicitis	Yes	No	Goiter	Yes	No	Multiple Sclerosis	Yes	No	Suicide Attempt	Yes	No
Arthritis	Yes	No	Gonorrhea	Yes	No	Mumps	Yes	No	Thyroid Problems	Yes	No
Asthma	Yes	No	Gout	Yes	No	Osteoporosis	Yes	No	Tonsillitis	Yes	No
Bleeding Disorder	Yes	No	Heart Disease	Yes	No	Pacemaker	Yes	No	Tuberculosis	Yes	No
Breast Lump	Yes	No	Hepatitis	Yes	No	Parkinson's Disease	Yes	No	Tumors/Growths	Yes	No
Bronchitis	Yes	No	Hernia	Yes	No	Pinched Nerve	Yes	No	Typhoid Fever	Yes	No
Bulimia	Yes	No	Herniated Disk	Yes	No	Pneumonia	Yes	No	Ulcers	Yes	No
Cancer	Yes	No	Herpes	Yes	No	Polio	Yes	No	Other: ______		
Cataracts	Yes	No	High Blood Pressure	Yes	No	Prostate Problem	Yes	No	______		
Chemical Dependency	Yes	No	High Cholesterol	Yes	No	Prosthesis	Yes	No	______		
Chicken Pox	Yes	No	Kidney Disease	Yes	No	Psychiatric Care	Yes	No	______		

Injuries/Surgeries: **Description:** **Date:**

Falls ______

______

Broken Bones: ______

______

Surgeries: ______

______

If not taking medication/vitamins/herbs/minerals and/or have no allergies, PLEASE specify NONE.

MEDICATIONS / DOSAGE/ FREQUENCY: ______

______

DRUG ALLERGIES: ______

______

VITAMINS/ HERBS/ MINERALS: ______

______

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ACCIDENT INFORMATION

Is this condition do to an accident? ☐ Yes ☐ No If Yes, Date of Accident: ____________

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other ____________

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Worker's Comp. ☐ Other

Attorney Name/Phone (if applicable) ____________

FAMILY HISTORY

Relative	Age If Living	Age At Death	Cause Of Death	State Of Health	Illnesses
FATHER					
MOTHER					
BROTHER(S)					
SISTER(S)					
MATERNAL G-FATHER					
MATERNAL G-MOTHER					
PATERNAL G-FATHER					
PATERNAL G-MOTHER					

SOCIAL HISTORY

EXERCISE

☐ None
☐ Weekly
☐ Daily
☐ Runs ☐ Walks ☐ Swims

HABITS

Smoking: ☐ Current Everyday ☐ Current Sometimes ☐ Previous ☐ Never

If current smoker, what is your level of interest in quitting on scale of 1-10: ____________

Alcohol: ☐ None ☐ Casual ☐ Moderate ☐ Heavy ☐ Wine ☐ Beer

Caffeine: ☐ < 3 drinks/day ☐ 3-6 drinks/day ☐ >6 drinks/day

Current Weight: ____________ Have you recently lost or gained weight? ____________ Height: ____________

Are you pregnant? ____________ Date of Last Menstrual Period: ____________

Patient/Guardian Signature: ____________ Date: ____________

Print Name: ____________ Relationship to Patient: ____________