PARADIGM CHIROSPORT
CERTIFIED CHIROPRACTIC SPORTS PRACTITIONER, ACBSP

Personal Information

Today's Date: _____ ☐ Male ☐ Female
Name: _____
Birth Date: _____ Age: _____

Home Address: _____
City: _____ State: ____ Zip: _____

Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____

Referred By: _____

Occupation: _____

Marital Status: ☐ Single ☐ Married
Spouse's Name: _____

Insurance Information

Company Name: _____
Address: _____
Phone: _____
Insured's SS#: _____
Group # (Plan, Local, or Policy #): _____
Primary Care Physician: _____
City: _____ State: ____ Zip: _____

Insured's Name: _____
Relation: _____ Birth Date: _____

Emergency Contact Information

Who should we contact: _____
Relation: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____

Reason for Today's Visit

Reason for today's visit: ☐ Emergency ☐ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Wellness Visit
Have you ever been treated by a chiropractor before? ☐ No ☐ Yes: Dr's Name _____
Have you seen a medical physician for this condition? ☐ No ☐ Yes: Dr's Name _____
Diagnosis by Medical physician: _____ ☐ I don't recall
Is this visit a result of: ☐ Work ☐ Sports ☐ Auto ☐ Trauma ☐ Chronic ☐ Other
Please Explain: _____
Is your condition getting worse? ☐ Yes, ☐ No, ☐ Constant, ☐ Comes and goes
Is your condition interfering with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other: _____; ☐ None
If so, please explain: _____
Have you experienced this condition before? ☐ Yes, ☐ No
If yes; when? _____
If no; when did this condition begin? _____
Please check if you have or have had any of the following, diseases, medical conditions, or procedures.

☐ Heart Attack	☐ Stroke	☐ Pace Maker	☐ Congenital Heart Defect
☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Artificial Valves	☐ High/Low Blood Pressure
☐ Hepatitis	☐ Glaucoma	☐ Diabetes (I, II)	☐ Heart Disease
☐ Anemia	☐ Chickenpox/Shingles	☐ Cancer	☐ Psychiatric Problems
☐ Asthma	☐ Emphysema	☐ Tuberculosis	☐ Kidney Problems
☐ Rheumatic Fever	☐ Difficulty Breathing	☐ Arthritis	☐ Artificial bone/joint/implant
☐ Lower Back Problems	☐ Frequent Headaches	☐ Neck Problems	☐ Fainting/Seizures/Epilepsy
☐ Chemotherapy	☐ Ulcers/Colitis	☐ Sinus Problems	☐ Venereal Diseases
☐ Appendicitis	☐ Arteriosclerosis	☐ Gout	☐ Alcohol/Drug Abuse

Have you ever? ☐ Been Knocked Unconscious, if so explain _____
☐ Been Treated for Spine/Nerve Disorder, if so explain _____
_____
☐ Had any surgeries, if so explain _____
_____