LARRY W. FULK, D.C. JAIME N. TRENT, D.C. JUSTIN L. FULK, D.C.

Patient Information

Full Name: ____ Today's Date: _______________
(First) (Middle) (Last)

Called Name (Name you prefer to be called): _________________________

Address: ________________________________ City: __________ State: ___ Zip: ______________

Home Phone: _______________ Work Phone: _______________ Cell Phone: ___________________

E-mail address: _______________________________________ Sex: □ Male □ Female

Race / Ethnicity: □ American Indian □ Alaska Native □ Asian □ African American
□ Hispanic or Latino □ Native Hawaiian □ Other Pacific Islander □ White

Primary Language: □ English □ Spanish □ Other: ____________________________________

Marital: M S W D Birth Date: ____/____/____ Age: ______ Social Security #: ______-____-_______

Do you have children? □ Yes □ No What ages?____

How were you referred to our office?

□ Friend/Family Member – Who may we thank:____

□ Yellow Pages □ Our Sign □ Newspaper Column □ Fitness Center □ Website □ FaceBook

□ Health Insurance Company □ Special Promotion: _________________ □ Other:_________________

Name of Primary Insurance Company: ____
Name of Secondary Insurance Company (if any): ____

Are you: ☐ The Insured ☐ Spouse ☐ Child
If you are not the insured, what is the insured's: Name:__________________ DOB:___________

Is your insurance: ☐ an Individual plan ☐ a Group plan (If Group plan who is the employer?)_________________

Occupation: _________________________ Employer: _____________________________________

Spouse: ____

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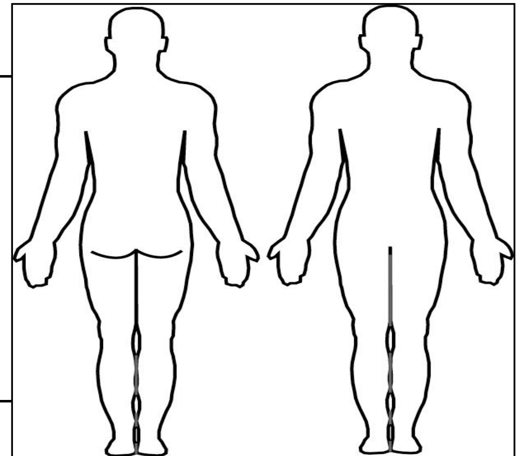
Fulk Chiropractic
Nutrition | Acupuncture

LARRY W. FULK, D.C.   JAIME N. TRENT, D.C.   JUSTIN L. FULK, D.C.

CASE HISTORY



Chief Complaint

What are the symptoms that brought you in to our office? ______________________
____

Indicate the location of your symptoms on the diagrams to the right

Are your symptoms a result of an accident or injury: □ Yes □ No
If "Yes" was the accident/injury related to:
□ Work □ Auto □ Other: ______________________________
Please describe the accident or injury:______________________________________
____

Past Conditions

Have you had or do you now have any of the following conditions?

Constitutional	□ Chest Tightness	**Neurological**	□ Osteoarthritis
□ Fever	□ High Blood Pressure	□ Nervousness	□ Fatigue
□ Unexplained Weight Loss	□ High Cholesterol	□ Irritability	□ Fainting
□ Unexplained Weight Gain	□ Problems Breathing	□ Dizziness	□ Frequent Colds
Eyes/Ears/Nose/Throat	□ Cold Hands	□ Depression	□ Diabetes - Type 1
□ Light Bothers Eyes	□ Cold Feet	□ Memory Loss	□ Diabetes - Type 2
□ Buzzing in Ears	□ Circulatory Problems	□ Anxiety	□ Menstrual Difficulties
□ Ringing in Ears	□ Stroke	□ Epilepsy	□ Sleeping Problems
□ Sinus Problems	□ Heart Problems	□ Seizures	□ Eating Disorder
□ Loss of Smell	**Gastrointestinal**	□ Convulsions	□ Alcoholism
□ Loss of Taste	□ Digestive Problems	**Other**	□ Drug Addiction
Cardiovascular	**Genito-urinary**	□ Cancer	□ HIV Positive
□ Chest Pains	□ Difficulty Urinating	□ Rheumatoid Arthritis	□ Other__________________

Family Health History

Indicate if any family members have had any of the following conditions? F = Father M = Mother S = Sister B = Brother

________	Arthritis	________	Disc Problems	________	Scoliosis
________	Back Pain	________	Headaches	________	Sinus Trouble
________	Cancer	________	Heart Trouble	________	Stroke
________	Diabetes - Type 1	________	High Blood Pressure	Other:	________________
________	Diabetes - Type 2	________	Pinched Nerve	________________________	

Which of the following most closely describes your smoking history?
□ currently - every day □ currently - some days □ former smoker □ never smoked

Current Medications

Current Medication List - include vitamin supplements (inform the front desk if you need more space)

Medication Name	Dosage	Type
EX: Lisinopril	10 mg	Oral Tablet
____________________	____________	____________________
____________________	____________	____________________
____________________	____________	____________________
____________________	____________	____________________

Allergies

Drug/Environmental Allergies: ____
____

Surgeries

List any major illnesses, injuries, falls, broken bones, surgeries, or accidents below, **and include dates if possible.**
Women, please include information about pregnancies and childbirth. ______________________
____
____

WOMEN ONLY: (THIS SECTION) Is there any possibility you may be pregnant? □ Yes □ No □ ?
Have you: □ Gone through menopause □ Had a hysterectomy

Print Name:______________________________ Date:__________________

Sign Name: ______________________________ Witness:______________________