Patient Instructions:
Please complete this form and then return to the receptionist.

PATIENT ENTRANCE DATA

PLEASE PRINT Today's Date ____/_____/_____

Legal Name: (Last) _____ (First)_____Nickname_____(Middle)_____

Preferred Title: _____ Birth date: _____/_____/_____ Age: _____ Gender: _____

Address: _____ Apt. #:_____

Zip: _____City: _____ State: _____

Phone: Home/Cell: (_____)_____Work: (_____)_____E-mail address_____

Referral Information

How did you find out about Sherman College Health Center?

- ❑ Advertisement
- ❑ Live Nearby
- ❑ Spinal Screening
- ❑ Newsletter
- ❑ Sherman College Intern _____
- ❑ Sherman College Student _____
- ❑ Sherman College Employee _____
- ❑ Current / Former Health Center Patient_____

Marital Status: ❑ S ❑ M ❑ W ❑ D Number of children: _____

Person to contact in case of emergency. Name: _____

Relationship _____ Phone: (_____)_____

Height: _____ ft. _____ in. Weight: _____ lbs. Native Language: _____

Handedness: ❑ Right ❑ Left ❑ Ambidextrous

Race: ❑ White ❑ Black ❑ Hispanic ❑ Asian ❑ Other _____

Highest level completed: ❑ Preschool ❑ Elementary ❑Junior High ❑ High school ❑ University ❑ Post Graduate ❑ Professional / Business school

Work History: (current or most recent first, include unpaid work, stay at home parent)

Type of job/position # Years Job activities Job related stresses

_____

_____

_____

Current Employer & Address:

Name: _____

Address: _____

Free Time activities; Sports, other Physical Activities, and Hobbies:

Type of activity Frequency

_____

_____

_____

Hours of sleep per night: _____ Quality of sleep: ❑ Good ❑ Fair ❑ Poor

Last Chiropractor Seen: _____ **Phone:** _____

Address: _____City: _____ State: _____

Spinal X-rays taken: Y N Date; ___/____/_____ Reason for care: _____

Last M.D. Seen (or other Health Care Provider): _____ **Phone:**_____

Address: _____ City: _____ State _____

Date of last visit: _____/____/_____ Reason for visit:: _____

Why are you seeking chiropractic care? _____

Is this your Major Health Concern? Y N If not, what is?_____

When did it start? _____/_____/_____ It started: ❑ Suddenly ❑ Gradually (please identify Condition)

Duration of problem / episode: ❑ _____Minute(s) ❑ _____Hour(s) ❑ _____Day(s) ❑ _____Week(s)
❑ _____Month(s) ❑ _____Year(s)

Does this condition interfere with your ❑ Work ❑ Sleep ❑ Daily activity

What do you think brought on your condition? _____

What makes it feel worse? _____

What makes it feel better? _____

Other Health Care Providers seen for this condition:

Date Condition Name and Type (MD, DO, DC, etc.) Results

_____

_____

Were you advised to restrict activities by any other Health Care Provider? ❑ Yes ❑ No

If yes, explain: _____

Describe Your Condition:

❑ Constant	❑ Intense	❑ Migraine	❑ Ache	❑ Localized
❑ Comes & Goes	❑ Mild	❑ Numb	❑ Dull	❑ Radiating
❑ Chronic	❑ Nagging	❑ Burning	❑ Sharp	
❑ Severe	❑ Cramping	❑ Diffuse	❑ Other _____	

Do You Have Difficulty:

❑ Sitting	❑ Standing	❑ Bending	❑ Walking	❑ Lifting
❑ Reaching	❑ Turning	❑ Driving	❑ Reading	❑ Exercising/Sports

Is this related to a work or auto accident? ❑ Yes ❑ No

Are you in litigation for any accidents? (Auto, Worker's Comp, etc.) ❑ Yes ❑ No

Are you a student at Sherman College? ❑ Yes ❑ No

Are you related to a student at Sherman College? ❑ Yes ❑ No

If Yes: Relationship: _____

Female Patients: Is there any possibility you are pregnant? ❑ Yes ❑ No

Consent to Chiropractic Care

Chiropractic care is based on clinical evidence of vertebral subluxations and not the presence or absence of pain, abnormal range of motion, or abnormal spinal curves. By the use of specific analysis and spinal adjustments, the goal of chiropractic is the correction of vertebral subluxations. X-rays taken are for the purpose of determining a chiropractic x-ray analysis, and to help determine if there may be any contraindications to chiropractic care.

- I understand that my record and/or x-rays are the property of Sherman College and will be used for teaching and research purposes and if at anytime I request a copy of my record and/or x-rays there will be an additional charge for copying them.
- I authorize Sherman College and its agents to administer care as needed, as indicated from examination findings
- I authorize Sherman College to release information to any other health care provider I am seeing and / or insurance company.
- I understand that if I am in litigation for any accident my settlement may be jeopardized by the fact that a student is rendering my care
- A parent MUST accompany his/her minor child on the first four visits to the Health Center and have authorized supervision on all other visits.

I have reviewed and certify that all of the information that I have reported above is true to the best of my knowledge and that I have read and understand the Consent to Chiropractic Care above.

Patient Signature: _____ Date: _____/_____/_____
(Custodial parent or legal guardian signature if patient is a minor)

Relationship to patient: _____

Witnessed by: _____ Date: _____/_____/_____

Intern Name: _____ Number: _____

Faculty DC: _____ Signature: _____ Date: _____/_____/_____

Office Use: Patient Type: ❑OP ❑PB ❑E ❑EF ❑SS ❑SF ❑R ❑Other _____
Patient Number: _____ Date Entered: _____/_____/_____ By _____