Fact Finding Form

Personal Information:

Patient's Name:______________________________ Today's Date: ________________
Age: ____________ Date of Birth: ____________ SS#: ______________ Male Female
Address: ______________________________ City: __________ State: ______ Zip: ______
Home Phone: ____________ Cell Phone: ______________ Work Phone: ______________
E-mail Address: ____
Employer Name: ________________________ Occupation: ______________________
Name of Spouse/Guardian: __________________________ Employer: ______________
Name of Nearest Relative: _________________________ Phone Number: ______________
Where did you hear about Goodman Chiropractic?
☐ Phone Book ☐ Newspaper ☐ Internet ☐ Referral ______________ ☐ Driving By

Insurance Information:

Do you have health insurance? Yes No Name of Insurance ______________________
Policy Holder: ____________ DOB ________ Group # __________ Policy # ____________
Do you have **secondary insurance**? Yes No Name of Insurance ____________________
Policy Holder: ____________ DOB ________ Group # __________ Policy # ____________

Other Medical Care:

List any doctors seen for your present condition. Dr. Name: ______________________
Have you sought care for health conditions in the last year? ☐ No, ☐ Yes, ______________
Was treatment administered? ☐ No, ☐ Yes, ______________________________
Do you take any medications? ☐ No, ☐ Yes, ______________________________
Prior hospitalization or surgery (List) ______________________________

General Health History – have you ever experienced or do you now experience:

☐ Allergies
☐ Arthritis
☐ Asthma
☐ Broken Bones
☐ Chest Pain
☐ Concussion
☐ Constipation
☐ Depression
☐ Diabetes
☐ Epilepsy
☐ Numbness/Tingling ______________________
☐ Digestive Problems
☐ Dizziness
☐ Fainting
☐ Fever (Recent)
☐ Fibromyalgia
☐ Headaches (Chronic)
☐ Heart Conditions
☐ Hypertension
☐ Insomnia
☐ Jaw Problems (TMD)
☐ Loss of Balance
☐ Loss of Smell/Taste
☐ Migraines
☐ Nausea
☐ Nerve Conditions
☐ Palpitations
☐ Vision Problems/Loss
☐ Sinus History
☐ Short Term Fatigue
☐ Other: ____________

If female are you pregnant? ☐ Yes ☐ No
Is your visit due to an accident? ☐ Yes ☐ No
If Yes, what type:
Auto (if so, please be sure to fill out the auto accident paperwork.)
Employment related (within the last year) describe: ______________________________
Other: ____