Pudenz Family Chiropractic
715 N Clark St.
Carroll, IA 51401
(712) 775-2418

Welcome to **Pudenz Family Chiropractic**

Live the life you deserve.

PATIENT INFORMATION

Date : _____

Patient Name : _____
Last First Middle Initial

Birthdate : _____

Age : _____

☐ Married ☐ Single ☐ Seperated
☐ Widowed ☐ Minor ☐ Divorced

Gender : _____

Address : _____

City : _____ State : _____ Zip : _____

Email : _____

Home Phone : _____

Cell Phone : _____

Occupation : _____

Whom may we thank for referring you? _____

INSURANCE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Jason Pudenz all 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 may use 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 Representative

Date : _____

PATIENT CONDITION

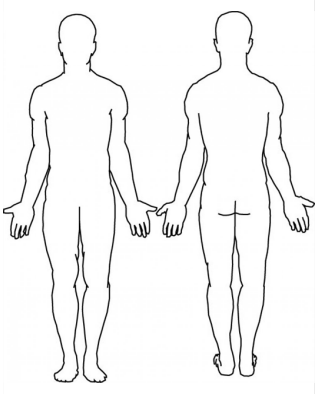
Reason for Visit : _____

When did your symptoms appear? _____

How often do you have this pain? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

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



Rate the severity of your pain on a scaled from 1 (least pain) to 10 (severe pain) : _____

Is the pain constant or does the pain come and go? _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Name and address of other doctor(s) who have treated you for your condition :

_____

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS

- ☐ Smoking — Pack/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Place a check to indicate if you have had any of the following :

AIDS/HIV		Emphysema		Measles		Rheumatic Fever	
Alcoholism		Epilepsy		Migraine Headaches		Scarlet Fever	
Allergy Shots		Fractures		Miscarriage		Sexually Transmitted Disease	
Anemia		Glaucoma		Mononucleosis		Stroke	
Appendicitis		Goiter		Multiple Sclerosis		Suicide Attempt	
Arthritis		Gonorrhea		Mumps		Thyroid Problems	
Asthma		Gout		Osteoporosis		Tonsillitis	
Bleeding Disorder		Heart Disease		Pacemaker		Tuberculosis	
Breast Lump		Hepatitis		Parkinson's Disease		Tumors, Growth	
Bronchitis		Hemia		Pinched Nerve		Typhoid Fever	
Bulimia		Herniated Disk		Pneumonia		Ulcers	
Cancer		Herpes		Polio		Vaginal Infections	
Cataracts		High Blood Pressure		Prostate Problem		Whooping Cough	
Chemical Dependency		High Cholesterol		Prosthesis		Other :	
Chicken Pox		Kidney Disease		Psychiatric Care			
Diabetes		Liver Disease		Rheumatoid Arthritis			

Injuries/Surgeries you have had (please include description and date) :

Head Injuries _____ _____

Broken Bones _____ _____

Surgeries _____ _____

Medications :

_____

_____

Patient Name (Printed) : _____ Date : _____

Patient Signature : _____