Fogarty
Chiropractic Life Clinic

LASTING PURPOSE

Kevin Fogarty, D.C., F.I.C.A. (Hon)

PLEASE FILL IN BELOW

NAME _____ DATE _____

STREET _____ APT _____ CITY, ST _____ ZIP _____

HM PHONE: _____ WK PHONE: _____ CL PHONE: _____

GENDER: M ___ F ___ DATE OF BIRTH _____ HEIGHT _____ WEIGHT _____

MARITAL STATUS _____ SS# _____ E-MAIL _____

Give reason for seeking chiropractic care: _____
Describe: _____

How long have you had this problem? _____
Are you under the care of any other physician? Yes _____ No _____
If yes, please list the doctors you are seeing, the condition you are treated for and the progress of care to date:

Please list any medication you are presently taking and the reason for taking it: _____

Please list all previous surgeries: _____
Please list any accidents, auto accidents, or broken bones you have had: _____

List any x-rays you have had in the last 2 years: _____

Have you been to a Chiropractor before? Yes _____ No _____ Date of last visit: _____
How long were you under care? _____ Condition treated for: _____
Name of Chiropractor: _____

Your occupation: _____
Duties you are required to perform regularly at work or home: _____

Habits:
Do you smoke cigarettes? Yes ___ No ___ # of packs per day: _____
Do you drink coffee? Yes ___ No ___ # of cups per day: _____
Do you consume alcohol? Yes ___ No ___ Approximately how much daily? _____
Do you exercise regularly? Yes ___ No ___ if so, what forms and how much? _____

Family Health History
Please describe the health of:
Father _____ Mother _____
Spouse _____ Children, give ages _____

FEMALES: Is there a possibility of you being pregnant? _____

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www.fogartychiropractic.com

Have you EVER had any of the following? Please check:

___Hay Fever	___Gout	___Thyroid Trouble	___Tonsillitis	___Gall Bladder Trouble
___T.B.	___Pneumonia	___Heart Disease	___Appendicitis	___Liver Trouble
___Allergies	___Pleurisy	___Cancer	___Arthritis	___Diabetes
___Polio	___Asthma	___High Blood Pressure	___Hypoglycemia	___Rheumatic Fever
___Varicose Veins	___Bowel Trouble	___Hemorrhoids	___Ulcers	___Kidney Trouble
___Slipped Disc	___Epilepsy	___Venereal Disease	___Other _____	

Are you PRESENTLY suffering from any of the following? Please check:

___headaches	___throat lumps	___palpitations of heart	___insomnia
___dizziness	___sore throat	___chest pains	___poor appetite
___nausea	___female problems	___back pains	___poor memory
___fainting	___cough	___hip pains	___inner tension
___change in vision	___shortness of breath	___leg pains	___nervousness
___nose bleeds	___indigestion	___neck pains	___blood in urine
___sinus pains	___heart burn	___shoulder/arm pains	___frequency of urination
___ringing in ears	___belching	___abdominal pains	___pain on voiding
___earaches	___vomiting	___other muscle pains	___cloudy urine
___ear discharge	___gas	___numbness	___change in weight
___impaired hearing	___constipation	___joint pains	___dry skin
___weakness	___diarrhea	___itching	___discoloration of skin
___fatigue	___rectal bleeding	___skin eruptions	___excessive sweating
___swelling of joints	___swelling of ankles	___ _____	___ _____

INSURANCE INFORMATION

Type of insurance: Regular Medical ___ Medicare___ Medicaid ___ Auto ___ Workers Comp ___

Name of Insured: _____ SS# _____

Insured's Date of Birth: _____ Name of Employer: _____

** Insurance Company:* _____ *Phone #:* _____

Insurance Company Address: _____

Policy # _____ Group # _____ Claim # _____

Patient Name: _____ Today's Date _____

Signature: _____ Relation to patient: _____