PATIENT INFORMATION FORM
DR. GEOFFREY C. ELLINGTON D.C.

NAME: _____ D.O.B.: _____/_____/_____

ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

SS#: _____-_____-_____

PREFERRED # TO CONTACT YOU: CELL OR HOME

CELL#: ( ) _____ HOME#: ( ) _____

WOULD YOU LIKE TO RECEIVE TEXT MESSAGES REGARDING APPOINTMENTS? YES OR NO

EMAIL ADDRESS: _____

MARITAL STATUS: M S W D # OF CHILDREN: _____

PATIENT OCCUPATION: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATIONSHIP TO PATIENT: _____

CELL #: ( ) _____ HOME #: ( ) _____

Tell us who referred you so we can thank them! _____

INSURANCE INFORMATION: (If you are not the primary Insured)

Insurance Co.:_____ ID No.: _____ Group No.: _____

Primary Insured's Name: _____ Date of Birth: _____ SS #.:_____

Primary Insured's Address: _____

Patient relationship to primary insured: _____

PATIENT SIGNATURE: _____ DATE: _____

Primary Care Physician: _____Phone#: ( ) _____

Have you had previous chiropractic care? Yes / No

Major Complaint: _____ Date of onset: _____

What activities aggravate this condition? _____

Is this condition getting progressively worse? Yes / No Constant Comes and goes

Other doctor's who treated this condition: _____

Please list surgical procedures and years: _____

_____

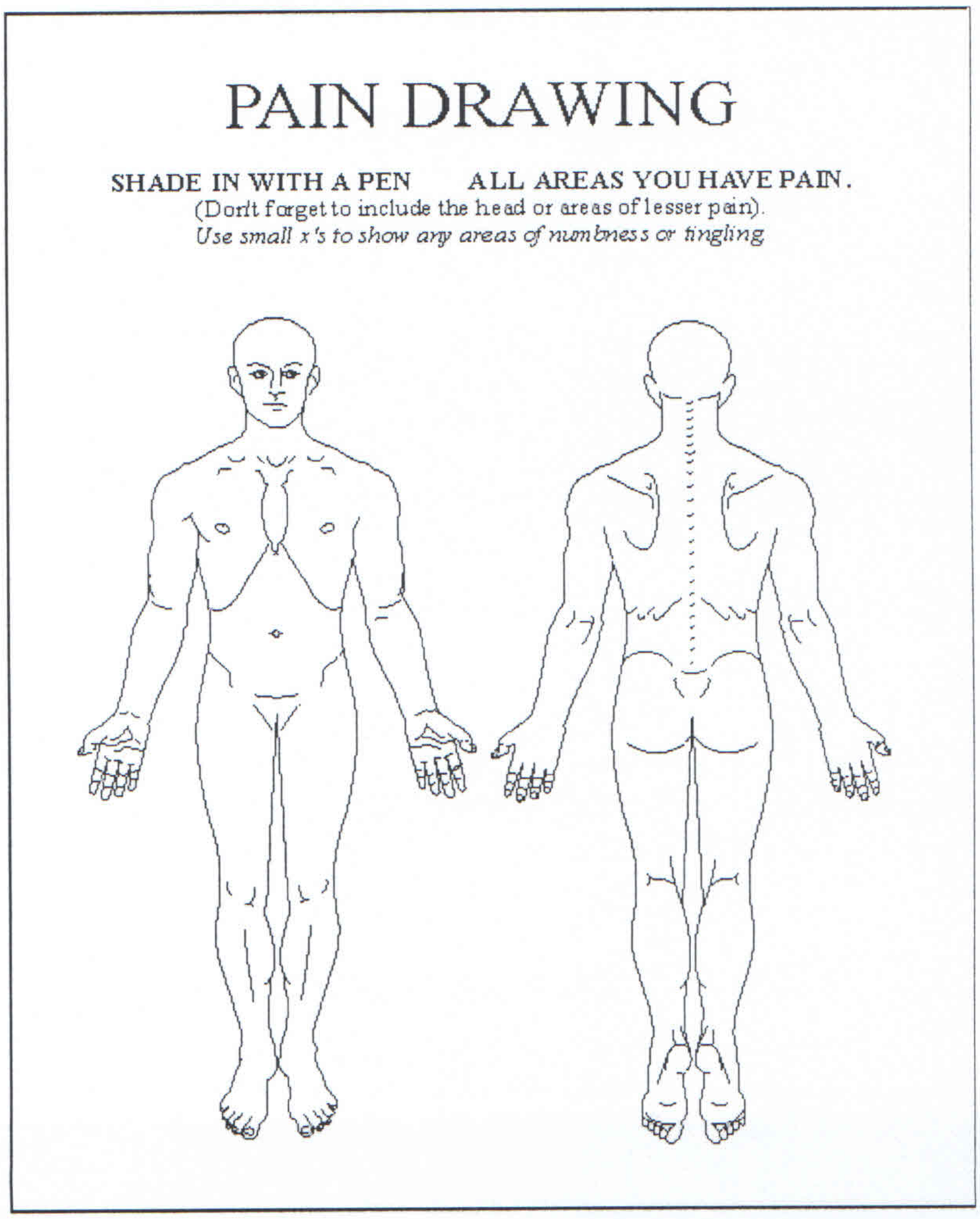
Please list medications you now take: _____

Do you wear:

Heel Lifts: Yes / No
Sole Lifts: Yes / No
Inner Soles: Yes / No
Arch Supports: Yes / No

Date of last Physical Exam_____

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW



HAVE YOU EVER SUFFERED FROM:

DIZZINESS: Yes / No

BACKACHES: Yes / No

HEART ISSUES: Yes / No

DIABETES: Yes/ No

ARTHRITIS: Yes / No

HEADACHES: Yes / No

ASTHMA: Yes / No

NEURITIS: Yes / No

DIGESTIVE DISORDERS: Yes / No

NERVOUSNESS: Yes / No

SINUS TROUBLE: Yes / No

NECK PAIN: Yes / No