Gallatin Chiropractic Clinic

1167 Nashville Pike Gallatin, TN 37066

Phone: 615-451-3400 Fax: 615-451-3544

www.gallatinchiro.com



Patient Full Name:		Soc	ial Security #	-
Address:	Ci	ty:	State	Zip
Primary Phone #:	Secondary Phone #	!	Work #	
Date of Birth:	Age: Sex: M o	r F Height:	Weight:	
Patient Employer:	0	ccupation:		
Employer Address:	C	ity:	State:	Zip
Marital Status (circle one): S M D W	Sep Email addr	ess:		
Responsible Party for Payment (Circle	one): Self Spouse Guardian	Other:		
Spouse's Name:	Spouse's _I	ohone #:		
Spouse's Employer:	Spouse's	Occupation:		
Emergency Contacts (Someone NO	Γ in household, please list at le	east ONE)		
Name:	Phone #		Relationship:	
Name:	Phone #		Relationship:	
Referring Physician	Phone #:		Last seen:	
Family Physician	Phone #:		Last seen:	
Other Chiropractor:	Phone #:		Last seen:	
Who referred you to our office?				
	Insurance Info	rmation		
Workman's Compensation or Auto Acc	ident Related? Yes N	lo If yes, date of inju	ıry:	
Primary Insurance Company:		ID #:		
Name of Insured:	Relationship to Insured:	SelfSpouse0	ChildOther Group #: _	
Secondary Insurance Company		ID #:		
Name of Insured:	Relationship to Insured:	SelfSpouse0	ChildOther Group #: _	
Patient/Guardian Signature:			Date:	

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Patient Name:	Date:		
Describe your symptoms:			
Where did your overstones having			
When did your symptoms begin?			
How did your symptoms begin?			
How often do you experience your symptoms? Constantly (76-100% of the day)	Please mark an X to indicate the areas where you feel pain, swelling, numbness of discomfort. Describe what you feel or observe in your own words. Write anywhere this area.		
Frequently (51-74% of the day)			
Occasionally (26-50% of the day)			
Intermittently (0-25% of the day)			
What describes the nature of your symptoms?			
Sharp Shooting			
Dull Ache Burning	10 11 2 11 70 - 17 1011		
Numbness Tingling			
How are your symptoms changing?			
Getting better			
Not changing)./)&() (
Getting worse			
During the past 4 weeks: None	Unbearable		
Indicate the average intensity of our symptoms 0			
How much has the pain interfered with your normal work (incl Not at all A little bit Mode			
How much of the time has your condition interfered with your			
	rately Quite a bit Extremely		
In general would you say your overall health right now is	, – ,		
Excellent Very Good Good	Fair Poor		
Who have you seen for your symptoms?			
	ctor Physical Therapist Other		
What treatment did you receive and when?			
	ney performed? X-Ray Date: CT Scan Date:		
MRI Date: Other testing Date: _			
Have you had similar symptoms in the past? Yes If you have received care in the past for the same or similar s	No		
Medical Provider Other chiropractor	Physical Therapist Other Date of last menstrual cycle?		
Have you tried anything for these symptoms? (heat ice vitan	nins, OTC Meds, etc.)		
List all medications, supplements, or vitamins you are taking	& for what condition:		
List all major accidents or injuries:			
	ch as cancer, heart disease, diabetes, etc		
Patient/Guardian Signature:	Date:		
r attent Guardian Olynature.	Date.		