

GALLATIN CHIROPRACTIC CLINIC

Mark B. Groff, B.S., D.C.

1167 Nashville Pike, Gallatin, TN 37066

(615)-451-3400

Full Name _____ Social Security _____ - _____ - _____

Address _____ City _____ State _____ Zip _____

Home # _____ Cell # _____ Work # _____

Date of Birth _____ Age _____ Sex M or F Height _____ Weight _____

Patient Employer _____ Occupation _____

Employer address _____ City _____ State _____ Zip _____

Marital Status (circle one) S M W D Sep Email _____

Responsible Party for Payment (circle one): Self / Spouse / Parent / Other _____

Spouse's Name _____ Spouse's Phone # _____

Spouse's Employer _____ Spouse's Occupation _____

Emergency Contacts (someone not in household, please list at least one)

1. Name _____ Phone _____ Relationship _____

2. 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 INFORMATION

Workman's Compensation or Auto Accident Related? ___ Yes ___ No If yes, date of injury ___/___/___

Primary Insurance Company _____ ID# _____

Name of Insured _____ Relationship to Insured: Self/Spouse/Child/Other Group# _____

Secondary Insurance Company _____ ID# _____

Name of Insured _____ Relationship to Insured: Self/Spouse/Child/Other Group# _____

Patient's Signature _____ Date _____

Gallatin Chiropractic Clinic

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Patient Name: _____

Date: _____

Describe your symptoms: _____

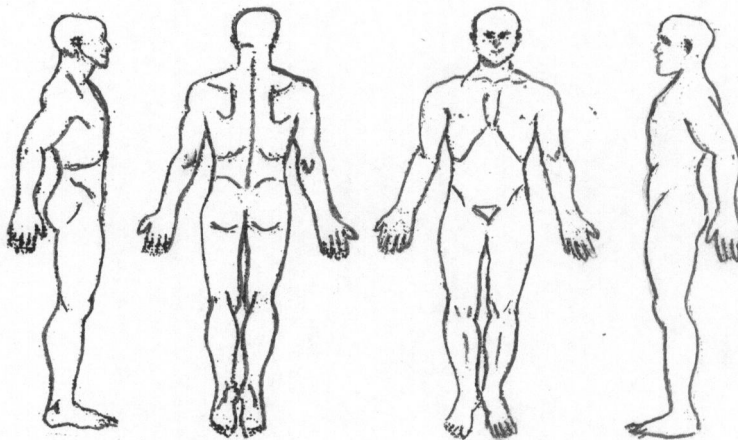
When did your symptoms start? _____

How did your symptoms begin? _____

How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day)
☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



What describes the nature of your symptoms?

- ☐ Sharp ☐ Shooting
☐ Dull ache ☐ Burning
☐ Numb ☐ Tingling

How are your symptoms changing?

- ☐ Getting better
☐ Not changing
☐ Getting Worse

During the past 4 weeks:

Indicate the average intensity of your symptoms

None 0 1 2 3 4 5 6 7 8 9 10 Unbearable

How much has pain interfered with your normal work (including both work outside the home and housework)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much of the time has your condition interfered with your social activities?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

In general would you say your overall health right now is ...

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Who have you seen for your symptoms? ☐ No One ☐ Medical Doctor ☐ Other Chiropractor ☐ Physical Therapist ☐ Other

What treatment did you receive and When? _____

What tests have you had for your symptoms and when were they performed?

X-rays date: _____ CT Scan date: _____
MRI date: _____ Other date: _____

Have you had similar symptoms in the past? ☐ Yes ☐ No

If you have received treatment in the past for the same or similar symptoms, who did you see?

☐ This Office ☐ Medical Doctor ☐ Other Chiropractor ☐ Physical Therapist ☐ Other

Are you pregnant? ☐ Yes ☐ No Date of last menstrual cycle? _____

What is your occupation?

☐ FT ☐ PT ☐ Self-Employed ☐ Unemployed ☐ Off Work ☐ Other

Have you tried anything for these symptoms? (heat, ice, vitamins, OTC meds, etc.) _____

List all previous surgeries: _____

List all medication, supplements, or vitamins you are taking & for what condition: _____

List all major accidents or injuries: _____

List any family history (Father, Mother, Brother/Sister, Children) such as Cancer, Heart Disease, Diabetes, etc: _____

Patient Signature: _____

Date: _____