CONFIDENTIAL PATIENT INFORMATION FORM

Dr. Michael B. Ackerman, D.C.

Name [Mr., Mrs., Ms., Dr.] _____Date_____ E-mail_____
Address_____City_____State_____Zip_____
Home Phone ( )_____Cell Phone ( )_____ Birthdate_____ Age_____
Employer_____Occupation_____ Work Phone ( )_____
Marital Status: M S W D How many children:_____ Soc. Sec. No. ___ ___ ___-___ ___-___ ___ ___ ___
Name of spouse_____Spouse's Occupation_____
Spouse's employer_____Spouse's Work Phone( )_____
Patient's nearest relative_____Relationship_____Phone( )_____
Referred by_____Date symptoms appeared or accident happened_____
Is condition due to injury or illness arising from your employment? [] Yes [] No
If so, did you report this condition to your work supervisor? [] Yes [] No Number of days lost from work _____
Has the patient ever had the same or similar condition? [] Yes [] No If Yes, describe _____
_____
Date of last physical examination_____Reason?_____
Doctor's name_____What was the diagnosis?_____
Females: Is there a chance that you could be pregnant? [] Yes [] No Date of last normal menstrual period:_____
What operations have you had, include age at time?_____
_____
What medical illnesses have you had, include age at time of illness?_____
_____
Previous history of accidents or injuries for which you sought treatment, include age at time?_____
_____
Have you ever been under chiropractic care? [] Yes [] No Reason:_____
Previous chiropractor?_____Frequency (Times/Mo)____Date of last treatment?_____

Have you ever suffered from any of the following: **N=I** have it **Now** **P=I** had it in the **Past** **F= Family** History

N P F	N P F	N P F	N P F
[] [] [] A.I.D.S.	[] [] [] Poor postural habits	[] [] [] Tuberculosis	[] [] [] Loss of consciousness
[] [] [] Allergy	[] [] [] Sciatica	[] [] [] Bruise easily	[] [] [] Paralysis
[] [] [] Head injury	[] [] [] Spinal curvatures	[] [] [] Bed-wetting	[] [] [] Bladder/Urination
[] [] [] Headaches	[] [] [] Swollen joints	[] [] [] Nosebleeds	[] [] [] Kidney problems
[] [] [] Fatigue/loss of sleep	[] [] [] Colon trouble	[] [] [] Sinus infections	[] [] [] Prostate trouble
[] [] [] Ulcers	[] [] [] High blood pressure	[] [] [] Diarrhea	[] [] [] Hepatitis
[] [] [] Anxiety	[] [] [] Low blood pressure	[] [] [] Cramps	[] [] [] Difficult digestion
[] [] [] Depression	[] [] [] Liver problems	[] [] [] Jaundice	[] [] [] Flatulence or belching
[] [] [] Numbness	[] [] [] Hemorrhoids	[] [] [] Chest pains	[] [] [] Breast/Gynecolg. prob.
[] [] [] Heart problems	[] [] [] Rapid heart beat	[] [] [] Hot flashes	[] [] [] Itching
[] [] [] Cancer/Lymphoma	[] [] [] Abnormal heart beat	[] [] [] Anemia	[] [] [] Fevers/rheumatic fever
[] [] [] Arthritis	[] [] [] Low back pain	[] [] [] Low blood sugar	[] [] [] Thyroid problems
[] [] [] Circulation	[] [] [] Mid-back pain	[] [] [] Arm/hand problems	[] [] [] Leg/foot problems
[] [] [] Stroke/T.I.A.s	[] [] [] Neck pain	[] [] [] Coughing	[] [] [] Varicose veins
[] [] [] Diabetes	[] [] [] Rapid weight change	[] [] [] Asthma	[] [] [] Swelling of ankles
[] [] [] Bursitis	[] [] [] Venereal Diseases	[] [] [] Memory loss	[] [] [] Lung problems
[] [] [] Eating disorders	[] [] [] Weakness	[] [] [] Eye/vision problems	[] [] [] Ear/hearing problems
[] [] [] Infection	[] [] [] Inflammation	[] [] [] Swelling	[] [] [] Poor Circulation

Have you ever had tingling, shooting pains, or numbness in any of the following areas:

Now	Past		Now	Past	
[]	[]	Shoulders	[]	[]	Hips
[]	[]	Arms	[]	[]	Thighs
[]	[]	Elbows/wrists	[]	[]	Legs/ankles
[]	[]	Hands	[]	[]	Feet

	Yes	No
Do you take vitamin or mineral supplements?	[]	[]
Do you think you may need supplements?	[]	[]

HABITS: **H**=Heavy **M**=Moderate **L**=Light **N**=None **P**=Past

	H	M	L	N	P	
Alcohol	[]	[]	[]	[]	[]	
Caffeine	[]	[]	[]	[]	[]	
Tobacco	[]	[]	[]	[]	[]	Pk-Years ___
Drugs	[]	[]	[]	[]	[]	
Appetite	[]	[]	[]	[]	[]	
Exercise	[]	[]	[]	[]	[]	
Sleep	[]	[]	[]	[]	[]	

Do you ever sleep on your stomach? Yes [ ] No [ ]

Do you wear or use any type of corrective supports for your...
[] Neck [] Back [] Shoulders, Elbows, Wrists [] Knees, Ankles, Feet [] Teeth/Jaws, **Pillow Type?** _____

Purpose of this appointment? (Describe your major complaints)_____
_____
What activities aggravate your condition?_____
What do you do to help your condition?_____
Is this condition getting worse? [] Yes [] No Is it more [] Constant …or does it [] Come and Go?
Is this condition interfering with your: [] Work [] Sleep [] Daily routine [] Other_____
What do you believe is wrong with you?_____
List other doctors seen for this condition?_____
Have you ever had any of these studies? [ ] X-rays [ ] MRI [ ] CT Scan [ ] Other _____ Dates?_____
Have you been treated for any health conditions by a physician in the last year? [] Yes [] No
If yes, please describe:_____
What medications or drugs are you taking?_____
_____
Do you have any allergies or adverse reactions to any drugs? Please describe: _____
Has there been any significant stress recently in your life? _____
Can you attribute your condition to any possible changes in exercise, work, leisure, or sleep habits? _____
_____

PAYMENT IS EXPECTED AT TIME OF EACH VISIT...

Name of person responsible for payment_____

Relationship to Patient _____Is Patient insured? [] Yes [] No Company_____

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare itemized billings to assist me in making collections from my insurance company, so **I give a General Release for this office to provide my insurance company any necessary medical information to process my claim**. However, I understand that all charges for health services rendered to me are my responsibility, and will be paid by me at the time I receive treatment. **Note**: For changes or cancellations of appointments, a **48 business-hour** advance notice is required to avoid possible full charges (e.g., for a 9:00 a.m. Monday appointment, please cancel by 9:00 a.m. Thursday, the week before).

Signature of Person responsible for Payment _____Date_____

To allow for payment by check or credit card, please also include the following information:

Driver's License #_____ State_____ Credit Card Type: Visa / MasterCard
Credit Card #_____Expiration Date_____
Name Exactly As It Appears on Your Card_____
Card Billing Address_____Zip_____

FOR OFFICE USE ONLY...
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If you have any questions or concerns or problems at any time, please feel free to contact the doctor's voice mail at (619) 687-7676. For emergencies, the doctor's cell phone number is (858) 472-1857. He will make every effort to return your call as soon as possible.

The integrity of your physical, emotional, and spiritual health is the doctor's primary concern, and you will witness this commitment in the energy and effort he dedicates to each session with you. The doctor extends you a ***warm welcome***, and promises to offer you an ever-new and powerful opportunity for Depth Healing!