301 South Fenway, Suite 101
Casper, WY 82601

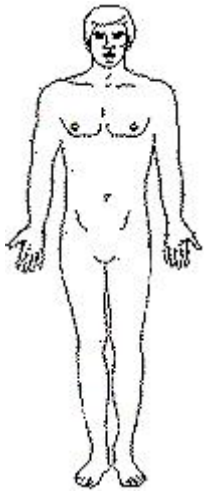
Patient Introduction Form

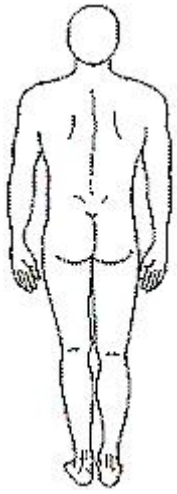
Patient Name:		Date:		SS#:	
Address:		City:		State:	Zip:
Height:	Weight:	E-Mail:	Date of Birth :		Home Phone:
Place Of Employment:		Job Description:			Work Phone:
Marital Status:		Spouse Name:			Other Phone:

Insurance Info		
Primary Policy Holder Information (if applicable): ***Same As Above*** ☐		
Name:		
Birth Date:	SS#:	Employer:

Family History

Have any of your blood relatives had any of the following? (check each that apply)									
Arthritis	☐	Heart disease	☐	High Blood Pressure	☐	Kidney Disease	☐	Tuberculosis	☐
Allergies	☐	Thyroid disorders	☐	Cancer(type)	☐				
Other:									





What problems or symptoms motivated you to visit us today? (Chief Complaint):

← Please mark Area(s) of pain on the Diagram .

Can You Describe the pain. (Type and Intensity):

When did this start? (approx):

Anything make it better or worse?

Have you received any treatment for this condition, (care or medication).

Mark “C” for currently and “P” for previously by any of the following you have had difficulty with:

Neck pain		Sleeping problems		Headaches		Numbness in arms or hands	
Back pain		Tension		Sinus problems		Pain in arms or hands	
Disc problems		Scoliosis		Asthma		Pain in legs or feet	
Jaw problems		Arthritis		Stomach problems		Numbness in legs or feet	
Joint swelling		Chest pains		Kidney problems		High blood pressure	
Painful joints		Heart problems		Bladder problems		Low blood pressure	
Diabetes		Gallbladder problems		Loss of balance		Frequent urination	
Cancer		Prostate problems		Swollen ankles		Recent fever	
Unexplained weight loss		Excessive fatigue		Smoking		Lights bother eyes	
Thyroid problems		Night pain		Frequent illnesses		AIDS/HIV	
Anemia		Hernia		Weakness		Unexplained blurred or double vision	
Loss of taste or smell		Difficulty swallowing		Slurred speech		loss of vision in one or both eyes	
Stroke, CVA, or TIA		Dizziness		other speech problems		Weakness, clumsiness, or loss of strength in your face, fingers, hands, arms, or legs	
Ringing, buzzing or any noise in your ear(s)		Unexplained loss of consciousness or momentary blackouts		Recent hearing loss in one or both ears		Numbness or loss of feeling in the face, fingers, hand, arms, legs, or other part of your body	
Unexplained temporary disorientation or confusion		Unexplained loss of consciousness or momentary blackouts		Sudden collapse without loss of consciousness			
Other:							

Past History

Surgeries:

Trauma:

Illness:

Medications:

Is there ANYTHING else you would like to tell the doctor?

Welcome to:

Alpine Chiropractic

Patient Signature: